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# The Canadian Nurse

VOLUME 48 NUMBER 11

NOVEMBER, 1952



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*The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of* THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*



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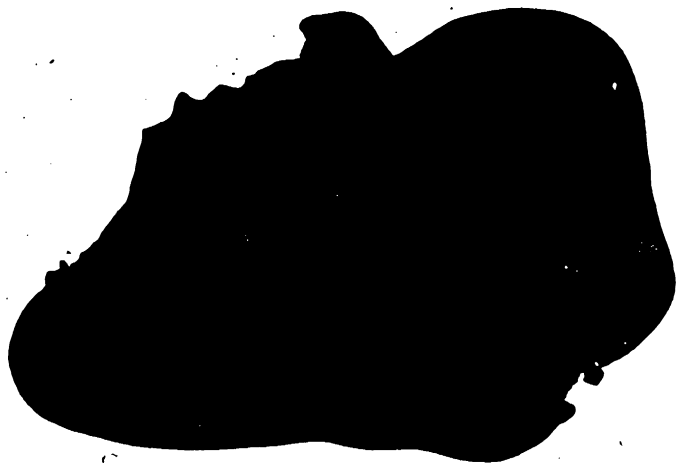

# Elastoplast

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**AS A MANY-TAIL BANDAGE**

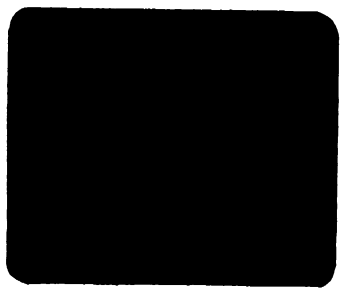

Fig. 1

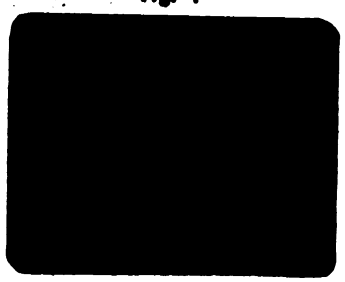

Fig. 2

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# Between Ourselves

*Very few nurses* have the unique distinction that belongs to our guest editor, Sister M. Stanislaus. She was president of the Association of Nurses of *Prince Edward Island* from 1950 to 1952. She held the same office for a two-year term—1937-39. Sister graduated from the Charlottetown Hospital where much of her professional life has been spent in various capacities. Currently, she is residence nurse and novice mistress at Mount St. Mary's, Charlottetown.

When it is realized that there are eight cities in Canada with a population larger than the grand total for the whole of P.E.I. it is easy to understand why some of the points, that Sister Stanislaus brings out in her editorial, came into being. Nurses in London, Ont., or Victoria, B.C., for example, can appreciate the overwhelming problems they would be up against if they were required, not only to secure legislation and set up standards for registration for the graduates of their immediate area, but also to make provision for their own registrar and school of nursing adviser. That the nurses of Prince Edward Island have done such an excellent job of meeting these problems is due in no small measure to the abiding enthusiasm each has for making the association a success. We offer our congratulations to the recently-elected president, Verna Darrach, and wish the A.N.P.E.I. continued success under her administration.

* * *

*The feature article* this month, written by Dr. Gordon H. Grant, discusses the painless, chronic contracture of the hand known as *Dupuytren's Contracture.* Guillaume Dupuytren, a French surgeon, 1777-1835, was one of the greatest of the early vascular surgeons. His catalogue of "firsts" makes interesting reading—first successfully to excise the lower jaw; to ligate the external iliac artery; to divide the sternomastoid muscle subcutaneously for torticollis, etc. One of his studies was of this condition that bears his name. The hand shows a marked thickening of the palmar fascia with flexion of the fingers, especially the third and fourth, upon the palm. The disease is of uncertain etiology and affects adult males chiefly.

* * *

*Winding up a demonstration* such as that conducted by the Canadian Nurses' Association, with financial assistance from the Canadian Red Cross Society, always brings an undertone of regret. The report from those who had been so closely associated with the actual program—Nettie D. Fidler, Eleanor Martin, and Margaret McPhedran—shows the strengths and weaknesses of the development with soul-searching clarity. Despite the fact their association was sponsoring it, the individual nurses have not given the unanimity of support to the whole project that might logically have been expected. Agnes J. Macleod's summary, on behalf of the Demonstration School Administration Committee, ends with a resolution that we should all wholeheartedly support.

Reprints of both of these articles will be available at cost shortly. *Requests for reprints* should be made to the *Canadian Nurses' Association, 1411 Crescent St., Montreal 25, Que.*

* * *

*A recent visitor* to our country, Millicent M. Bathgate, public health nursing officer with the Ministry of Health, London, Eng., has asked us to publish the following letter:

"I wonder whether it would be possible for you to spare me space in *The Canadian Nurse* to say a very sincere 'Thank you' to all those nurses and friends of nurses who extended me such a warm welcome and generous hospitality during my 12 weeks' visit to Canada this summer on a British Commonwealth and Empire Nurses War Memorial Scholarship.

"Pressure of time occasionally made it difficult for me to express adequately my thanks for the excellent arrangements made for me, both professionally and socially. I am hopeful that no one will think I was not appreciative. Indeed I find it difficult to express all that I feel towards Canada and the Canadian people. The whole trip was a most exciting experience which I shall remember always."

---

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# New Products

*Edited by* PROFESSOR F. N. HUGHES

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Administration—One or two tablets ½ hour before and ½ hour after meals or as directed by physician. The tablets should not be chewed but broken up and taken in a little water.

## APOLAMINE TABLETS

Manufacturer—Winthrop-Stearns of Canada Ltd., Windsor, Ont.

Description—Each tablet contains: Luminal 15 gm., atropine sulfate 0.1 mg., scopolamine HBr. 0.2 mg., benzocaine 100.0 mg., riboflavin 4.0 mg., pyridoxine HCl 2.5 mg., niacinamide 25.0 mg.

Indications—Antiemetic, vomiting of pregnancy, travel sickness, x-ray sickness, etc.

Dosage—1 or 2 tablets.

## CAL-VI-TAB

Manufacturer—E. Gallo, Montreal.

Description—Each dragee contains: Dicalcium phosphate 5 gr., ferrous sulphate 3 gr., vitamin D 333 U.I., thiamine 1.5 mg., riboflavin 2.0 mg., niacinamide 10.0 mg., pyridoxine 1.0 mg.

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Administration—2 to 3 dragees per day.

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Manufacturers—Abbott Laboratories Limited, Montreal.

Description—Each tablet contains 50 mg. of 3, 4-(2′-methyl-2′-methoxy-4′ phenyl) dihydropyranocoumarin, an anticoagulant related to Dicumarol but more potent, more prolonged in action, and less toxic to small vessels.

Indications—For oral use in prophylaxis and treatment of intravascular clotting, used either alone or in conjunction with heparin—e.g., in post-operative thrombophlebitis, phlebothrombosis, pulmonary embolism, etc.

Administration—100 to 200 mg. on first day, then 12.5 to 50 mg. on any succeeding day that prothrombin activity is greater than 25%. Prothrombin activity must be determined before daily dose is given. For prolonged administration, dose may be adjusted so that prothrombin tests may be made each 5 to 7 days.

## DEPO-TESTOSTERONE

Manufacturer—The Upjohn Company, Toronto, Ont.

Description—10 cc. vials, 50 mg. per cc. Each cc. contains: Testosterone cyclopentylproprionate 50 mg., chlorbutanol 5 mg., cottonseed oil q.s.

Indications—In both sexes for its anabolic effect. *Male:* As an aid in restoring mental and physical vigor; impotence of endocrine etiology; hypogonadism; low sperm count; cryptorchidism. *Female:* Functional uterine bleeding, menopausal syndrome, carcinoma of breast, dysmenorrhea, premenstrual tension, control of lactation, relief of breast engorgement.

Administration—For intramuscular use only.

## DIAPECTOL

Manufacturer—N. C. Polson & Co. Ltd., Montreal.

Description—Each fl. oz. contains: Pectin 5.50 gr., collodial kaolin 100 gr., zinc sulfocarbolate 0.80 gr.

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Administration—Adult—2 tablespoonfuls every two hours or as necessary. Children—One or two teaspoonfuls according to age.

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Andelman, Gerald, Rambar, and Kagan report in their new study* that prematurely born infants fed meat showed a significantly higher hemoglobin concentration as compared to the control group.

"At 20 weeks . . . the meat-fed or experimental group exceeded the control by a significant amount. The mean difference in hemoglobin concentration of the experimental group and that of the control group was 1.0 gm. per 100 ml. . . . Both received more than adequate amounts of iron added to the diet."

This study supports the earlier findings of Leverton and Clark, in which meat begun at 6 weeks in formula of full-term infants not only checked drop in hemoglobin characteristic of this age, but actually promoted hemoglobin and red blood cell formation.

**Pediatrics, April 1952, Vol. 9, No. 4, pg. 485*

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**TESTED UTILIZATION**—The proteins and fats of Swift's Meats for Babies are as well utilized as the same nutrients in milk, by premature infants. *Sisson, Emmel and Filer, "Meat in the Diet of Prematures," Pediatrics, 7, 89,* (1951).

**TESTED FORMULA**—For the allergic infant. A formula of Swift's Meats for Babies enriched with minerals, fat and carbohydrate is suggested as an effective milk substitute for infants allergic to milk proteins. *McQuarrie and Ziegler, "Nutritive Value of Mineral-Enriched Meat and Milk," Pediatrics, 5, 210,* (1950).

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### POLYCIN

**Manufacturer**—Pitman-Moore Co., Guelph, Ont.

**Description**—An antibiotic ointment containing 400 units Bacitracin and 8,000 units Polymyxin B per gm. in Fuzene, a special diffusible base combining carbowax diesters and petrolatum.

**Indications**—For prophylaxis and treatment of local infections due to organisms sensitive either to Bacitracin (i.e., especially Gram-positive) or Polymyxin (i.e., especially Gram-negative).

**Administration**—Spread a thin layer directly on the affected area. Repeat once or twice each 24 hours.

### METHIUM

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**Description**—Hexamethonium chloride.

**Indication**—Hypertension.

**Administration**—Orally, dosage determined for each patient, usually starting with 125 mg. four times daily (once or twice if sympathectomized or on salt-restricted diet). Dosage should never exceed 5 gm. daily and will usually be below 3 gm. daily.

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**Description**—Beta-gamma-dihydroxypropyl-theophylline—a stable, neutral derivative of theophylline, relatively non-toxic.

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**Administration**—Average dose orally—0.2 gm. four times daily.

### MYQUAPEN

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**Description**—Aqueous suspension containing in each cc. 300,000 I.U. Procaine Penicillin G.

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Most of us "older folks" share the guilt for the mess this world is in—not so much because of what we did but of what we did not do. We have been so busy with our personal affairs and our professional ambitions that we have neglected our responsibilities as participating citizens in the civic life of our community and nation. We have let the political "George" do it. . . Some of us have been so engrossed in the theory of education, so busy teaching citizenship by textbooks and lectures that we forgot to teach it by example.

*—Nation's Schools*



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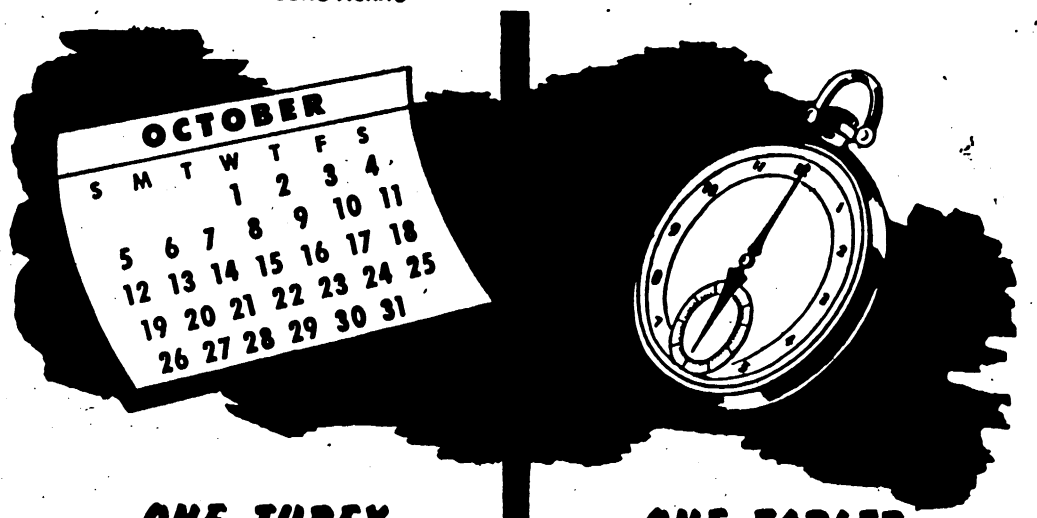


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# The CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

*VOLUME FORTY-EIGHT* *NUMBER ELEVEN*

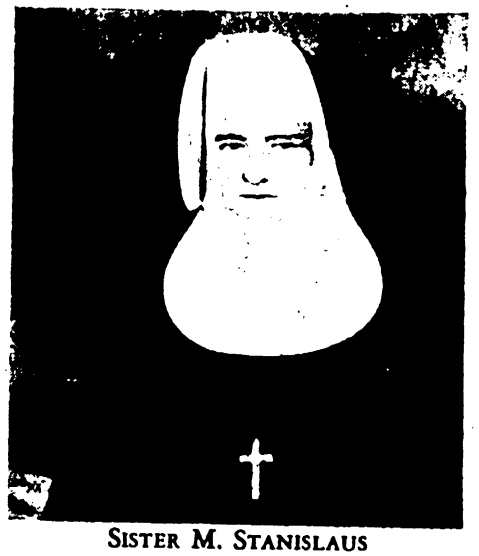
MONTREAL, NOVEMBER, 1952


# Achievement in the Garden of the Gulf

The social and economic trends of the 20th century tend to make it difficult for the small to survive. For this reason many of us in the nursing profession on Prince Edward Island regret that, when the foundations of this great Dominion were being laid, the Atlantic Provinces, which had already discussed plans for a union among themselves, did not give the matter more serious consideration and enter the Dominion as a united Maritimes. Are the advantages of having our red-shored Island, the Micmacs' Abegweit, a province in its own right, offset by certain disadvantages?

Whatever the answer to that question might be, we must view the situation as it actually exists. No doubt, we often feel ourselves in the position of the proverbial frog in the farmer's can of cream, hopeful that we, too, if we struggle long enough, will find ourselves on top of a golden mound—the butter of professional security for the A.N.P.E.I.

Perhaps the Federal Health Grants to our association have marked the beginning of this golden mound for, without this assistance, the dream of a provincial office could not have been realized. Miss Muriel Archibald must have been buoyed up with great hope when she left the C.N.A. National Office in the fall of 1950 to become the first provincial registrar and school of nursing adviser. It was a proud day in the history of our association when we



SISTER M. STANISLAUS

could refer professional questions to the registrar at our own provincial office.

Shortly after the arrival of the registrar, first-year qualifying examinations, set by the newly-formed, nurse-controlled Board of Examiners, were written in the schools of nursing for the first time.

With the coming of the New Year 1951, the Nurses' Licensing Act, the second in Canada, became effective. Since then the membership has more than doubled. The few delinquent cases brought to the attention of the Committee on Discipline have been satisfactorily settled. The following incident will serve to illustrate the general good will which prevails towards membership. A graduate, aged 79, arrived at the provisional office with the announcement, "Well, I've come to go to jail." Years ago she had retired to Prince Edward Island to run a chicken farm but, with no nurses available, the neighbors had frequently claimed her time from the chickens. Remuneration was small; consequently, she did not feel inclined to pay professional fees. The case was solved by the kindly and prudent registrar who placed her in the category of a nursing assistant and sent her away happy.

The Licensing Act brought another significant change—the raising of the standard of entrance to our schools of nursing to junior university matriculation. With this change reciprocal registration, both in Canada and United States, became easier. Hand in hand with the raising of the standards went an increase in the number of qualified instructors in our nursing schools. Better teaching facilities and an increase in hospital beds have provided more clinical experience for the students. We should like to add that, as a result, applications to schools of nursing have considerably increased but such is not the case. Although larger classes are being graduated, the public murmurs and the government frowns when candidates without matriculation, who are turned from our doors, are received into other Canadian schools of nursing!

The private duty nurses, particularly the married group, are to be commended on their service to nursing. Two community registries, at Charlottetown and Summerside, are maintained by this little group without much assistance from outside sources.

Public health nursing services, like those of other provinces, have been greatly expanded. Miss Ruth Ross, who received her B.Sc. in public health nursing in June, 1951, is a full-time health instructor at Prince of Wales College Normal School. In addition to her role of health teacher, she directs suitable students into the nursing field.

The division of the province last fall into two chapters—Charlottetown and Summerside—greatly facilitates the work of the association. At the annual meeting in 1951, the inclusion of *The Canadian Nurse* in the membership fee was approved. It is hoped that the reading of our national *Journal* by a larger number will increase professional interest and understanding.

The last important move in nursing within the province was the 1952 legislation for the Licensing of Nursing Assistants in Prince Edward Island, to become effective in September of this year. The Act was sponsored by the Minister of Health who requested the A.N.P.E.I. to administer it. We are hopeful that, with the assistance of the non-professional worker, a more stable nursing service will be available to the patient—our first responsibility as nurses.

SISTER M. STANISLAUS
*Immediate Past President*
*Association of Nurses of*
*Prince Edward Island.*

---

*There will be general interest* in the four papers prepared by the participants in the panel discussion presented at our convention last summer. Following the article on "Nursing Research" that we published recently, a study of the pattern developed by this team in their research into the ***activities of the head nurse*** will prove both interesting and profitable.

Gordon H. Josie's paper appears on page 895. The others will be included next month.



# Dupuytren's Contracture

GORDON H. GRANT, M.D., F.R.C.S. (C.)

Dupuytren's contracture is an irregular thickening of the palmar fascia. This structure, when normal, is a thin, glistening white sheet of fascia, spreading from the base of the palm to the interdigital rim. Prolongations run along each side of each digit, including the thumb, as far as the middle phalanges. In addition the fascia sends down, in the distal palm, eight longitudinal septa to arch over the tendons and the neurovascular bundles. These septa fuse with the interosseous fascia. The fascia is also attached intimately, especially at the palmer creases, to the deep layers of the skin.

This condition was first described more than 300 years ago. The Baron Dupuytren,[1] in 1831, first set forth an accurate description of the anatomic variations found in the contracture. These variations run from a minor nodular thickening of the fascia, most commonly over the metacarpophalangeal joint of the ring finger, to a diffuse thickening and shortening of the entire fascia, including the digital extensions. Any or all of the digits may be drawn into flexion by contracture of the digital slips, the ring finger being most commonly affected. The deep volar structures: the tendons, the joint capsules, the nerves and blood vessels, and the palmar skin itself may progressively be involved in the shortening process.

The skin may be drawn into funnel-like crypts, all but impossible to cleanse. The condition ordinarily causes little pain. There may be tingling in the involved areas and the nodules may be tender on heavy pressure.

## ETIOLOGY

The cause of the condition is obscure. Familial influence is undoubtedly strong; it is not unusual to find several members of a family involved. Trauma was once believed to play a leading role. This view is disputed by many, notably by Brunnell,[2] who states that he has seen the contracture more often in persons of sedentary occupation than in laborers. Compensation boards rarely admit nowadays that trauma may be a cause. Long quiescent contractures may begin suddenly to advance in persons who turn from sedentary occupations to the hobbies of retirement. These are apt to include gardening and carpentry. It may be that the unaccustomed pressure of tools acts as an aggravating agent.

The condition is much more common in men. Persons displaying the contracture tend to develop excessive joint stiffening after relatively minor injury. Race seems to exert little or no influence.

## TREATMENT

Non-surgical treatment has not, to date, resulted in any consistent record of cure. Vitamin E was originally claimed to produce recession of the contracture. It has been moderately successful in one patient in the writer's hands. X-ray seems to effect temporary softening of the bands but there is prompt recurrence. Physiotherapy is not of benefit and, if pursued too vigorously, may increase the disability. Cortisone, which inhibits the production of fibrous tissue, has been advocated as a potentially valuable agent. The effects of cortisone are most transitory, though, and it is hard to see how so evanescent a drug could successfully combat so chronic a disease. Cortisone may be of value after operation and this phase will be discussed later.

The treatment of choice appears to be surgical excision of all the involved fascia. It is supremely important that the operator have a precise knowledge of the anatomy and of the surgical technique. Disasters have been numerous in the past. The writer has known of one instance of removal of all the digital nerves to the fingers from the

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Dr. Grant is a surgeon in Victoria, B.C.

heel of the palm to the webs of the digits. That a serious lawsuit resulted is of secondary importance; the real calamity was that a relatively minor annoyance was transformed into a life-long and most serious disability.

Luck[3] and others have, from time to time, advocated subcutaneous division of the contracted bands. This does not ordinarily result in permanent cure. It is useful, though, as a preliminary to later resection where the contracture is severe and of long duration. The flexed digits may then be drawn into extension by active traction splinting; the dimpled, greasy skin may be stretched and cleansed. Primary healing, without skin grafting, may be achieved after operation and this prompt healing greatly speeds the return of the hand to good function.

This fasciotomy is not without its own dangers. Tendons and nerves may be and have been divided. These injuries require specific repair and this may involve a tendon graft. This is a major procedure, requiring immobilization of the affected part of the hand for three weeks. In this time the joints of a hand involved in contracture may stiffen beyond hope of successful restoration.

A variety of incisions are now in use. The traditional L incision runs from the base of the index finger—along the distal palmar crease—to the ulnar side of the hand and thence proximalward to the side of the hypothenar eminence. The triangular flap thus formed is turned up to expose the palm. A "strap" incision is widely used; the two arms parallel the distal palmar crease and the almost longitudinal thenar crease around the base of the thumb. Each of these incisions yields excellent exposure; their drawback is that the circulation of the skin is put in jeopardy. Primary healing is of extreme importance after resection; death of a patch of skin means a secondary skin graft or slow secondary epithelization. Either process results in scar that may cancel the benefits of an excellent dissection.

The writer[4] has advocated a wavy, zigzag incision down the palm, running from the base of the digit worst affected to the heel of the palm. The resulting scar does not keloid if it does not cross the palmar creases at a right angle. Hamlin[5] has used several small incisions parallel to the palmar creases. Secondary incisions may be necessary to resect the thickened bands along the digits. These should be mid-lateral and must not cross the small creases on the front and back of the digits.

The choice of anesthesia must be made in the light of the emotional stability of the patient. Brachial or triple nerve block are satisfactory in stable patients; nervous persons react badly to novocain and complain bitterly of the pressure of the tourniquet.

A tourniquet is absolutely mandatory and must be inflated to 300 millimetres of mercury. The arm must be elevated and stripped before the cuff is inflated. It is worse than useless to inflate the cuff to a pressure of 160 millimetres; we all drive our systolic pressures above the 200 millimetre mark more often than we realize. A cuff at low pressure merely lets arterial blood leak through and blocks venous return. To attempt this dissection in a hemorrhaging field is to invite disaster. Bunnell has produced the colorful simile that such an effort is no more rewarding than to try to fix a watch in a bottle of ink. The delicate neurovascular tree may be damaged beyond repair; the endless sponging rasps the palmar structures and devitalizes the skin. The resulting edema and pain are likely to be great. Such a hand may be very difficult to mobilize; the patient may fail, especially to recover full flexor power and this is a far worse disability than his original partial loss of extension.

The most satisfactory tourniquet, in the writer's hands, is the sphygmomanometer cuff, firmly bandaged with gauze. It is a useful safeguard to clamp the tubes close to the cuff with rubber-covered intestinal forceps. This produces fairly rapid deterioration of the tubes but this minor added expense is more than balanced by the mere saving in gauze and ligature material.

This tourniquet may safely be left in place for 70 minutes. At the end of this time, or if the dissection is finished





sooner, the cuff is deflated and massive moist compresses are held firmly in the wound for five minutes. All but the larger vessels cease to bleed by the end of this time. These are ligated with No. 0000 plain catgut and the wound is gently but thoroughly flushed out with warm saline. This washes out all tiny detached fragments of tissues and small blood clots. Lavage should not be vigorous; a forceful stream may wash the thrombi out of the unligated vessels. The cuff is reinflated and repair of the wound is completed.

The surgeon should sit comfortably on a padded stool with the arm before him on a firm armboard or narrow table. Lighting and technical assistance should be the best available. Instruments should include straight and curved ophthalmologic scissors, a battery of fine hemostats, and an adequate assortment of small rake and band retractors. Scalpel blades dull rapidly on the tough fascia and replacements should be constantly available in assorted patterns. Thumb forceps should be fine and should never be used to grasp the skin margins.

Only the finest of ligature and suture materials should be used. Coarse catgut produces scar; it has no place in an operation designed to get rid of scar tissue. Ophthalmic silk should be available in sizes 6-0 or 7-0. Even able and experienced surgeons occasionally divide the small digital nerves and these can be repaired successfully only with the finest of non-traumatic silk. The wound, depending on the operator's tastes, may be repaired with stainless steel, silk or cotton.

The dressing of the hand is of fundamental importance. The wrist should be cocked at 30 degrees of dorsiflexion; the fingers should be in slight flexion, to minimize the tension on the palmar skin, and should be spread apart. Fluffed gauze is applied as a thick compression pad to the front and back of the hand, wrist, and forearm. A thick sponge rubber pad, trimmed to fit the palm, may be applied over this and a narrow crepe bandage is lightly wrapped over this deep layer. Accurately molded plaster slabs are applied front and back and, finally, a second layer of fluffed gauze is applied to front and back, rather more firmly, with a second crepe bandage.

The result is an even, spongy pressure, ample to prevent oozing but not likely to produce either local pressure necrosis or interference with the circulation of the digits. The latter should be lightly immobilized for eight days but should not be bandaged in compression unless they have themselves required dissection.

The digits may be mobilized after the eighth day. The palmar skin, from which the pathologic fascia literally has been shaved away, is now in essence a flap graft and requires compression for from 15 to 21 days.

Cortisone is now in fairly wide use in the post-operative phase. It appears to lessen edema and fibrosis, by inhibiting the growth of new fibrous tissue and by blocking the hyaluronidase spreading factor. It was initially believed to delay wound healing but recent experimental work seems to show that in therapeutic dosage it does not do this.

As with all surgical patients, a high-vitamin, high-protein intake is important. Wounds of the hand, as with all wounds, heal badly in the presence of avitaminosis and hypoproteinemia.

Antibiotics are given routinely after operation. The writer prefers to inject 5cc., locally, of a mixture containing one gram of streptomycin and one million units of pencillin. Penicillin may be given intramuscularly for four days after operation.

The hand should be elevated for at least 12 hours after operation. The tips of the digits should be in view and should be closely observed. Cyanosis and chilling are cardinal signs of danger. The surgeon, in person, should be warned at once when these signs appear.

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# Food, Drug, and Intrinsic Allergy

C. H. A. WALTON M.Sc., M.D., F.A.C.P.

## FOOD ALLERGY

Allergy to food is probably common. It has been observed and described under various names for centuries. "One man's meat is another man's poison." But it is only in the past third of a century that the concept of allergy to food has been developed and placed on a scientific basis.

In general, clinical food allergy occurs more commonly in children but is seen at all ages. Allergic manifestations in infants and preschool children are frequently due to foods. As the child grows older, inhalants play a part more frequently and these tend to supersede the good sensitivities. His gastrointestional tract matures and offers less opportunity for the absorption of large molecules, such as protein. However, food sensitivity does persist in many adults, demonstrated especially in such conditions as urticaria, migraine, gastrointestinal allergy, and asthma. Food allergy is to be distinguished from certain food intolerances or idiosyncrasies. Some foods, because of their chemical make-up, may cause undesirable symptoms which act pharmacologically rather than allergically. the common intolerance of many people to cabbage, onion, radish, cucumber, eggs, etc., is an example of idiosyncrasy rather than allergy.

Food sensitivity may manifest itself in any type of allergic reaction. It accounts for a great many of the allergic reactions in infancy and throughout life it is the chief cause of urticaria and migraine. Food reactions are characterized by a reaction time varying from one-half to 24 hours, in contrast to the immediate reaction usually occurring with inhalants. Symptoms due to food allergy may occur acutely at long intervals when they are due to rarely eaten or seasonal foods. Chronic food allergy, of course, occurs when the food allergen is a common one in the diet. Duration of symptoms may vary from half an hour to several days and up to two weeks. Allergy to common foods is not continuous but periodic, with rhythmically occurring refractory periods.

The most common syndromes produced by food allergy are gastrointestinal disorders involving abdominal discomfort—gaseous distension, crampy pain, diarrhea, pruritis ani, etc.; urticaria and angioedema; atopic dermatitis; headache; rhinitis and asthma. As experience accumulates, food sensitivity is recognized more frequently in adults with respiratory allergy.

Food allergens reach the reacting tissues following ingestion with subsequent digestion and absorption or by inhalation and absorption—e.g., flour dust. They may also reach the infant patient by breast milk.

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The quantity and quality of the allergic foods determine not only the severity but also the occurrence of symptoms. Symptoms may occur only when large amounts of the particular food are taken or in the more sensitive when very minute amounts are swallowed. It is also known that the length of time of storage and cooking influences the reactions very materially. Individual tolerance to a given allergenic food varies from time to time and also with such circumstances as the effects of other foods, condition of the intestinal tract, or infection. Fatigue, alcohol, emotional upsets, and excitement may be very important secondary factors. Food sensitive asthmatics are often better in the warm months of the year.

The foods which most commonly are found to be responsible for food allergy are:

1. *Cereals:* Particularly wheat, oats, and corn.
2. *Eggs:* Sensitivity to the white part of hens' eggs in particular. It is probable that egg yolk less often causes a true allergic reaction.
3. *Milk*—the lactalbumin fraction seems to be the most important.
4. *Meat* sensitivity is less common. Pork and chicken are the worst offenders.
5. *Fish* in one of its many forms is not an infrequent cause. Fish products, such as fish glue, caviar, and cod liver oil, are included. Fish reactions are apt to be very severe.
6. *Vegetables* when raw are more prone to cause trouble. The more frequent offenders are beans, peas (including peanuts), potato, tomato, and onion.
7. *Fruits* are frequent causes of acute seasonal urticaria but may also cause chronic symptoms, especially the citrus fruits, bananas, and apples.
8. *Nuts* are not infrequent offenders and may produce very severe symptoms, especially urticaria and asthma.
9. *Beverages.* Coffee and tea are uncommon food allergens but cocoa (including chocolate) is a most important one. Beer is a quite common allergen.

## DIAGNOSIS

The diagnosis of food allergy is often difficult. Food must be considered in all allergic problems. A knowledge of its characteristics and a very careful history may suggest a diagnosis. Skin tests are seldom helpful and are most often misleading. There are many technical reasons for this and perhaps the most important is that food is greatly changed by cooking and digestion. Extraction methods are as yet not entirely satisfactory. A negative skin test does not rule out a suspected food allergy and a positive reaction is of no importance unless confirmed by clinical trial. Too many doctors and patients restrict a food permanently and needlessly because of a positive skin test. Skin tests may be dangerous, especially with fish, nuts, and eggs.

As skin tests are usually of little value in diagnosing food allergy, it is necessary to employ test diets, known as elimination diets. The ideal elimination diet would be simply water but, in an effort to maintain nutrition during the test period, a diet is designed which eliminates most of the common food allergens and provides subsistence on a limited list of foods which may be allergens but are unlikely to be.

The best known elimination diets are those of Rowe and there are many modifications of them. The principle is always the same. It is important to emphasize that elimination diets are for diagnosis only. They should not be persisted in for more than two or three weeks for fear of serious dietary deficiency. In general, it is desirable to continue an elimination diet for a period of three weeks. If there is no improvement in that time immediate return to a full diet should be permitted. If definite and even striking improvement occurs, it might be assumed that the improvement has been due to the elimination of the many foods not permitted in the diet. This, of course, is not proof but simply an assumption. In the event of such improvement foods are then to be added back to the diet, one at a time, at intervals of two or three days.

When a previously eliminated food is added it is done in an effort to provoke trouble, if trouble is going to occur. For this reason the test food

should be added in large amounts, larger than the patient would ordinarily eat. If no symptoms occur within two to three days it may be assumed that the food is innocent. It then becomes a part of the original basic diet and another food is added. In this systematic way the diet may be gradually restored to normal. If there are any foods which demonstrably cause symptoms it may be accepted that these foods are true allergens. It would be wise not to accept a single test of this kind but the suspected foods should be tried again after a symptom free interval of a few weeks. If, again, symptoms are produced following the administration of the suspected foods this may be accepted as definite clinical proof. There is a great danger in permitting patients to start on these elimination diets and losing sight of them. It is not an uncommon experience to have patients report to a consultant who finds that they have followed some diet received elsewhere, for very long periods of time, without really knowing that they are doing themselves grave harm.

It is apparent that, if such limited diets as these are persisted in for any length of time, serious dietary deficiencies may ensue. This is a particular danger in childhood. Not infrequently it happens that the suspected or proven food allergen is of considerable dietary importance. Physicians must see to it that the dietary deficiency is made up some other way. For example, in the case of milk, there are suitable milk substitutes available on the market such as Mul Soy. If these substitutes are not tolerated suitable vitamins and calcium salts are prescribed. The physician must be thoroughly satisfied that the particular food does, indeed, cause the trouble. before permitting the patient to continue permanent elimination of it from his diet. When a food is demonstrated to be an offender there is little or no difficulty in persuading the patient to avoid it permanently.

While a patient is on an elimination diet, it is important that he keep a complete and accurate food diary. What is eaten at each meal should be recorded, both qualitatively and quantitatively. Any symptoms occurring day by day should be recorded, together with the medications taken to deal with those symptoms. Even without the use of an elimination diet a carefully kept food and symptom diary is of the greatest value diagnostically and should be used often. It has the drawback of being very tedious to both patient and doctor. The physician's ingenuity is often taxed in handling elimination diets and in helping the patient to eliminate one or more specific foods. The problem of substitutes of equivalent nutritional value and the problem of special recipes require much consideration.

There is disagreement as to whether or not it is possible to desensitize the patient to food. It is impossible to desensitize by the hypodermic method as is done in the case of inhalants. Inhalants are extracted in the respiratory mucosa via tissue fluids but not digested. That is to say, in effect, the offending allergen is a watery extract of the offending material made by the tissue fluid. In the case of foods or other articles which are swallowed, digestion occurs in the intestinal tract so that the materials that cause the allergic reactions are products of digestion. They are not the original substance nor are they simple aqueous extracts. An extract of food, therefore, in its undigested or unprepared state has no relation whatever to the digested material absorbed and which acts allergenically in the patient. There is evidence, which I think is convincing, that in some instances adequate desensitization is possible by giving infinitely small quantities of the food orally in gradually increasing doses, to tolerance. This seems to be particularly effective in the case of milk. If a solution of one part of milk in several thousand parts of water is made and a tiny quantity of the diluted milk given daily with very gradual increases over a period of months, it is possible to achieve sufficient tolerance so that the patient can take small quantities of milk such as the amount which appears in butter or even the amount which would be used in tea or coffee. Occasionally, the patient is able to take larger amounts and this, of course, is a great comfort





to him. Egg desensitization can sometimes be achieved. I believe that, in the case of milk, an effort at desensitization is worth considering in all patients, particularly children.

### Drug Allergy

Another class of ingestants which may produce important allergic reactions is that of drugs. Commonly used drugs, such as aspirin, are found to act as allergens rather frequently. While they are not proteins, they are believed to unite with a plasma globulin to produce a hapten which acts as the specific allergen.

Drugs can be the specific cause of hay fever, asthma, urticaria, dermatitis, etc. They must always be thought of and it is wise to eliminate all drugs from an allergic patient for a test period. Being so commonly used they are very apt to be unsuspected by patient and physician. Drugs of the aniline series are particularly prone to be troublesome. These drugs are also prone to affect the hematopoietic system, producing such phenomena as agranulocytosis, thrombocytopenia, and acute hemolysis. The classic example of this type is amidopyrine.

It is interesting to observe that, while some asthmatics obtain relief from the use of aspirin, others react violently to it. Thus we have an example of the pharmacological action of the drug compared to its possible allergic action. Aspirin sensitive asthmatics are often very difficult to manage. Their asthma is quite intractable and may indicate an intrinsic type of case. The mortality in these cases is high. Aspirin sensitivity is not seen in children.

A group of drugs, which has become important in recent years in the field of allergy, is the antibiotic group. The effect of penicillin in causing a serum sickness-like reaction is now widely recognized. It is perhaps less widely known that the newer antibiotics—aureomycin, terramycin, and chloromycetin—also cause urticaria-like reactions almost indistinguishable from that seen with penicillin. These drug reactions are somewhat different from the usual spontaneous allergy seen with inhalants and ingestants. They resemble acquired sensitivity similar to anaphylaxis artificially induced in the animal. There are many other examples of drug allergy such as that seen with the use of liver, insulin, etc. The serum sickness type of allergy is often temporary and may disappear permanently in a few months. That seen with liver may persist indefinitely.

A special note regarding *morphine* is necessary. It is doubtful if morphine ever acts as a true allergen but it does cause release of histamine which may account in part for its serious effects in allergic people. Its depressing effect on respiration and the cough reflex add greatly to its danger. Morphine has killed many asthmatics and it should *never be given to an asthmatic person on any account.*

### Intrinsic Allergy

There is a large group of cases manifesting diseases which we now consider allergic, such as asthma, atopic dermatitis, etc., which behave exactly as other allergic problems do but in which we are unable to make a specific etiological diagnosis. This group represents approximately one-third of the total. Pathologically such cases are difficult, if not impossible, to distinguish from the others. They have been classified in different ways. Rackemann introduced the term "intrinsic allergy." By this he meant that extrinsic allergens could not be demonstrated and he presumed that the allergic reactions arose from allergens produced within the body. Such allergens might arise from a focus of chronic infection such as might be seen in the accessory nasal sinuses or in dental abscesses. Occasionally endocrine factors appear to be important, particularly those related to the sexual function. Other workers used the term "non-allergic" for this group, meaning that they had not been able to demonstrate an allergic factor.

This group is very difficult to account for and exceedingly difficult to manage. There is little doubt that if demonstrable sources of chronic infection, such as chronic hypertrophic sinusitis, can be adequately dealt with, some of these cases may do well. Treatment resolves itself into the use of very radical surgery which

is successful only in a few skilled hands. Too often, inadequate nasal surgery leads to a grave aggravation of a seriously troublesome asthma.

There are cases in which there is much secondary infection in the bronchial tree. Such cases may be primarily allergic asthma but manifest infection by purulent sputum and perhaps by general physical symptoms. In those cases in which infection appears to be an important factor, it would be proper to consider the question of vaccine therapy. Some workers believe that carefully prepared autogenous vaccines are valuable. These vaccines are obtained by cultures, taken through the bronchoscope or from hypertrophic tissue removed surgically from the sinuses. That such vaccines are specific is evidenced by the fact that their administration will reproduce symptoms and, indeed, there is some reason to believe that careful desensitization with these vaccines will produce worthwhile clinical results. A number of other competent observers believe that equally good results may be obtained using stock bacterial vaccines.

That these cases are, indeed, allergic is strongly suggested by the fact that some of them manifest severe aspirin sensitivity. It is certain that aspirin can be classified as an extrinsic allergen. There can be little doubt that it acts in a typically allergic manner. Of course, the aspirin does not account for the primary disease. It is simply an incident in the disease. Perhaps some day we shall have sufficient knowledge to acquire diagnostic techniques which will indicate causes in these otherwise unexplained cases.

Intrinsic allergy can occur at all ages, although it is probably seen more often in the older age group, particularly in those in whom the disease developed suddenly in late life. However, a word of caution should be given. Because allergic disease develops in late life it does not follow that it is intrinsic in type. Very often simple extrinsic factors are demonstrable in the older age group.

This vexing problem of intrinsic, infective or non-allergic asthma, or whatever name one may call it, is important if only to emphasize that the management of allergic disease involves the discovery of the offending allergen. As the offending allergens are so often not discovered or are unsuitable for definite treatment, it follows that this large group, representing a third or more of the total, becomes a problem of symptomatic management only. With better medical attention, with, more diagnostic care, and with newer techniques which we hope will develop, this group should become smaller and smaller. I am afraid, however, that there is a tendency for it to become too large. That is to say, it undoubtedly includes individuals who have demonstrable and controllable extrinsic allergic factors which have not been discovered because of inadequate diagnostic study.

In this discussion of intrinsic allergy I have perhaps rather over-stressed asthma. I think that it is probable that intrinsic allergy applies to other allergic manifestations also. Certainly it includes allergic rhinitis, urticaria, and some allergic dermatoses.

This is the group which is so often classified as psychiatric. Space does not permit a discussion of the problem of psychiatry in allergic disease. I feel that psychological causes are seldom if ever primary in allergic disease. There can be no doubt that the severe, persistent, and gravely disabling disease seen in many of these cases does lead to psychological disturbances. One cannot be frequently and severely dyspneic without becoming very disturbed and anxious.

Individuals vary greatly in their capacity to stand severe disability so that some of those who are most difficult to control do present striking psychological disturbances but they can be explained quite readily as secondary to the disease and not primary When the disease can be effectively controlled, whether one does it symptomatically by drug therapy or by use of the new endocrine weapons such as ACTH or Cortisone, the psychological disturbance rapidly resolves. Occasionally one sees highly unstable patients who, among other things, have perhaps moderate asthma. It is understandable that both doctor and relatives think that asthma is a manifestation of the individual's neurosis. Very often in such patients the asthma is due to a readily recognized cause. The asthma is controlled but the neurosis and its other manifestations continue. The allergic patient, particularly the one who is suffering severely for a long time, deserves sympathy and understanding. On rare occasions he may deserve special psychiatric care but continued attention must be directed to his primary disease.

In concluding this discussion it is important to recall that allergy is a constitutional diathesis and that allergic patients can and do have the other diseases to which non-allergic people are heir. In evaluating an allergic problem it is not only necessary to consider the patient's psychological state and his allergic problem but it is also necessary to make a careful differentiation from manifestations of other disease. The management of allergic disease resolves itself into an attempt to find the specific causes, which are often multiple, and into removing and otherwise controlling these causes. If and when this is not successful, as in perhaps a third of the cases (so called intrinsic allergy), symptomatic management then becomes the only method of treatment available at present.





# In Memoriam

**Madalene Mary Baker,** who graduated from St. Joseph's Hospital, London, Ont., in 1922, died suddenly on August 29, 1952, at the age of 51 following a heart attack. Miss Baker's name will live on in the annals of professional nursing in Ontario for she was largely responsible for the development and organization of the private nursing registries currently functioning in all the major centres in that province. Believing that the only sound basis for such registries was under the egis of the R.N.A.O., she served as a secretary of that body as her program expanded, visiting and supervising the registries. She also assisted the A.N.P.E.I. in the inauguration of their new licensing act a few years ago.

* * *

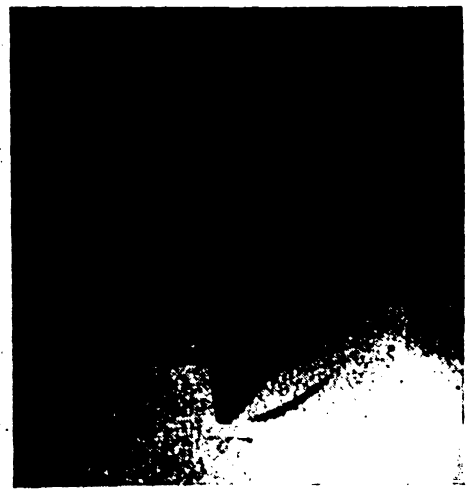
**Gertrude M. Bennett,** who graduated from the Montreal General Hospital in 1905, died in Ottawa on August 31, 1952, at the age of 72. She had been in indifferent health for several months but was active to the last.

Miss Bennett commenced her career as a graduate nurse by taking charge of the outpatient department at M.G.H. At the youthful age of 26 she became matron of the Brockville (Ont.) General Hospital remaining there until 1914. During the next five years she engaged in private nursing in Ottawa, becoming lady superintendent of the Royal Ottawa Sanatorium in 1919. Five years later Miss Bennett undertook the task of organizing a school of nursing in the newly formed Ottawa Civic Hospital. There she remained as director of nursing until her retirement in 1946. During her 22 years of service, she graduated hundreds of nurses who bear the imprint of Miss Bennett's strong sense of professional responsibility and devotion to duty.

Chairman of District 8, R,N.A.O., second vice-president of the C.N.A., a member and, for several years, chairman of the Council of Nursing Education for Ontario, long a member of the National Board of the Victorian Order of Nurses for Canada, Miss Bennett served her profession faithfully and well. A moving tribute to her memory was passed by the city council of Ottawa recently.

* * *

**Diana B. Brown,** who graduated from St. Luke's General Hospital, Ottawa, died



GERTRUDE M. BENNETT

suddenly in Ottawa on September 13, 1952. She had served in the private nursing field, during a few years of which she was a member of the Board of Directors of the Community Nursing Registry.

* * *

Myrtle Agnes Ellis died in Olds, Alta., on August 13, 1952, at the age of 59.

* * *

Bernice (Quilty) Lafontaine, a graduate of St. Michael's Hospital, Toronto, died in Toronto on August 19, 1952, following an illness of several months. Born in Saint John, N.B., she had served on the staff of St. Michael's Hospital and also, for several years, in private nursing.

* * *

Frances Marie Lenarduzzi, an intermediate student in the school of nursing of St. Paul's Hospital, Vancouver, died suddenly on August 13, 1952, at the age of 19.

* * *

Bessie MacKay, a graduate of Glace Bay (N.S.) General Hospital, died on August 24, 1952, at the age of 47.

* * *

Lillian MacLellan, a graduate of St. Mary's Hospital, Montreal, died on September 5, 1952, following a lengthy illness. Following graduation, Miss MacLellan was placed in charge of the maternity ward. In 1940 she went overseas with No. 1 Canadian General Hospital. Upon receiving her discharge in 1946, she joined the Department of Veterans Affairs and was appointed matron of the Lachine D.V.A. Hospital. Later she took charge of the St. Hyacinthe Veterans Hospital, a post she held until her illness.

* * *

Edith Anna Moffatt, who graduated from the Royal Victoria Hospital, Montreal, in 1902, died suddenly at Renfrew, Ont., on August 8, 1952. Following graduation, Miss Moffatt specialized in surgical nursing in such widely separated situations as Presbyterian Hospital, Chicago; Wellesley Hospital, Toronto, and the Winnipeg General Hospital. In 1925 she accepted the post of superintendent of nurses at the Brockville General Hospital. She had retired in 1946.

* * *

Margaret Spaul, a native of Ontario who trained at Roosevelt Hospital, New York, and who served as a nursing sister with the United States Army during World War I died in Toronto on August 15, 1952, at the age of 73. Retiring in 1932, Miss Spaul had made her home in Toronto.

* * *

Isobel (Moseley) Ward, who graduated from the Royal Victoria Hospital, Montreal, in 1926, died on October 11, 1952. Prior to her marriage Mrs. Ward had engaged in private nursing.

* * *

Marion Willison, who retired from active duty many years ago, died in North Vancouver in August, 1952, at the age of 76.

## Metropolitan Health Committee, Vancouver

The following are staff changes:

Appointments— *Doris Clifford* (Royal Victoria Hosp., Montreal, and University of British Columbia public health nursing certificate); *Mavis Coleman* (Vancouver Gen. Hosp.; B.A., B.A.Sc.); *Margaret Donevan* (Kingston Gen. Hosp. and B.N.Sc., Queen's University); *Louella Downing* (Regina Gen. Hosp., Sask.; University of Alberta p.h.n. cert.; B.N., McGill U.); *Kathleen MacDonald* (University Hosp., Edmonton; B.Sc., U. of A.; Master of Nursing, U. of Washington); *Mary McDougall* (Royal Jubilee Hosp., Victoria, and U.B.C. p.h.n. course); *M. Meagher* (B.Sc. in p.h.n., St. Louis U.) to V.D. Clinic; *Grace Pettifor* (U.H., Edmonton, and B.Sc., U. of A.); *Elizabeth Putnam* (Royal Jubilee Hosp., Victoria; B.A.Sc., U.B.C.).

Resignations—*C. Barrell* and *Mona Bell* to be married; *Queenie Donaldson* from the Division of V.D. Control to accept a position with WHO as a member of a team of consultants going to Ethiopia; *Mmes Mabel Donovan, Annette Forster, H. Hermann, M. Robinson, H. Rodin; Mrs. W. Farrell* from Medical Division, City Social Service Dept.

*Caroline Harvie* has returned to the staff after a year in England and the Continent. *Jean McEwan* is on the staff for a year as an exchange nurse from Kitchener while *Kathleen Cameron* is replacing Miss McEwan. *Lara Thordarson*, who has returned to the staff with her Bachelor of Social Work degree from U.B.C., will be attached to the Mental Health Division as nursing consultant in mental health.



# The Metropolitan School of Nursing

### What We Were Trying To Do

In the autumn of 1946 the Canadian Red Cross Society made it financially possible for the Canadian Nurses' Association to establish a school in which to try a new form of preparation for bedside nursing. The school thus endowed came into existence in January, 1948, through an arrangement with the Metropolitan General Hospital, Windsor, Ontario, and concludes its demonstration in the autumn of 1952.

In this school we were trying to do several things. First, we wished to show that an "independent" school of nursing could produce nurses more efficiently than a school whose program is conditioned by the service needs of a hospital. By "independence" is meant financial and administrative independence, through which alone educational independence can be secured. There was, of course, no thought that nursing schools could be independent of practice in hospitals. What the school claimed as necessary to a satisfactory curriculum and its execution was freedom from the necessity of staffing wards and departments around the clock, whenever and wherever someone was needed on duty, and regardless of what the student was supposed to be learning at the time. In short, the purpose was to conduct a school of nursing as an educational institution for the purpose of training good bedside nurses, prepared also to be eligible for further training in any of the special fields of nursing.

Second, we wished to find whether adequate bedside nurses could be produced in a shorter period than three years if the school controlled the use of the students' time in a program which was designed to meet only their learning needs and not the needs of the hospital.

It was fairly generally admitted that nursing students were spending some time on the wards otherwise than in learning to nurse or in learning to do so only incidentally and wastefully. Just how much time was wasted was not known but the assumption was that by proper planning and use of time probably about a year could be saved. The course was to include all the recommended experiences. The original curriculum was designed to cover 25 months, though applicants were told that a few more months might be found necessary.

Third, we hoped, if possible, to convince prospective nurses, active nurses, the allied professions, and the public that this was a sounder method of training which would result in more and better nursing.

Finally, it was hoped to convince governments of the need for financial support for nursing education.

### Where We Feel We Succeeded

1. We who have worked in the school, at least, think that good nurses were produced and in the shorter period. (The first two classes graduated at the end of 25 months and the third at the end of 24 months. The fourth and final class will graduate in exactly two years.) The judgment of the school staff is subjective, undoubtedly: nevertheless they were experienced people and not determined to prove something at any cost. We were not entirely without objective means of evaluation during the course. The school is an approved nursing school in Ontario and is inspected by the same school visitor who inspects all nursing schools. It has been reported on favorably. Reports from three schools where our students affiliated do not indicate that these students suffered by comparison with others. Our students write the registration examinations of the province and results have been satisfactory. The health record of our students has been exceedingly good. Students have successfully completed post-graduate work. At the time of writing, the report of an expert from the field of general education, who has been evaluating the program, is not known but is about to be given. The ultimate evaluation of a training program is the product in action.

We await with interest the reports of the employers of our graduates. Certainly they seem to have been highly employable, though it is not forgotten that this has been in a time of shortage. One of our objectives has been to produce nurses who liked nursing and continued to nurse. It is true that a good many have married; it is also true that nearly all have continued to nurse.

2. We feel that we succeeded in "integrating" the theory and practice to a degree which is exceptional in nursing education. While this is by no means a new idea in general education, it has not, on the whole, been thought necessary to teach student nurses the theory of obstetrics (for example) and to give them the clinical practice in obstetrics at the same time. Moreover, there is not only the matter of this correlation within one subject or field of experience; there is also the necessity of weaving in the psychological, social, and health aspects of nursing throughout all the experience. This to a considerable extent we have done and we feel it is a great deal of the reason for the speed and thoroughness of our students' learning. So big a field cannot be elaborated in this brief report and we hope that much thought and research will be spent on the problems of achieving reasonable integration in the next decade.

3. The demonstration has elicited an unexpected amount of interest. The school has had many visitors. Strangely enough, the number from other countries has exceeded that from Canada. Some highly intelligent and interested citizens of Windsor gave their loyal support and help, particularly the Board of Directors of the school: Mr. J. Ewart Carruthers, Mr. Gordon Dewar, Mrs. R. J. Coyle, Mrs. John Gray, Mrs. Wallace Campbell, Mr. W. H. Hiscock, Mr. Herman Bradley, Mr. C. C. Barron. And also: Mrs. Herman Savage, Mr. Gordon Fraser, Mr. Jack Kent, Miss Laura Lambe, Mr. Arthur J. Rheaume, Miss Mabel Hoy, Miss Marjorie McCutcheon, Miss Hilda McInnerny.

4. It must be accounted a very important success that the Federal Government and the Province of Ontario have both contributed financially to the support of this school.

### Where We Feel We Did Not Succeed

1. Satisfactory relations were not established with the Board and administration of the Metropolitan Hospital. This was particularly evident in the fact that the principle of the control of the students' time by the school was continually in dispute. From the time of the earliest negotiations this matter was emphasized as being of paramount importance; and in both the first and second contracts it was specifically stated and accepted. During the first months of the school's existence it appeared that this question would cause no difficulty. In February, 1950, a most carefully drawn new contract, in which the Canadian Nurses' Association ceded other rights under the old contract but insisted again on the essential nature of the time element, was declared satisfactory and signed by the association and the hospital. Immediately following this there was renewed and ever-increasing discussion on this point. The official argument was frequently stated in this form: The idea of the training is a very fine one, and it would appear that the students are learning to be good nurses; but the hospital is not getting any use of the students. It appears that "use" here must mean that the students do not "cover" any department where help may be needed at any time and where the hospital is not prepared to meet this responsibility through its employed staff —this, despite the fact that the hospital did have many thousands of hours of good nursing care from the students and the unstinting contribution of highly qualified instructors who spent the greater part of their time on the wards of the hospital.

In justice to the nursing staff of the hospital, it should be stated clearly that the complaints discussed above did not come from them at any period of the demonstration. In fairness to the school, too, it must be recorded that, in a time of emergency in the hospital, any attempt to follow the planned program exactly was abandoned and a good deal of help was given by both the students and staff of the school.

One benefit from the school which the hospital might legitimately expect is a





supply of graduate nurses. From February, 1950, to September, 1951, 45 students had been graduated; in October, 1951, 25 of these had been employed at the Metropolitan Hospital and 13 were then employed there. In October, 1951, 28.88 per cent of all our graduates were on duty at the Metropolitan Hospital. The majority of these were not Windsor residents.

2. Nurses were by no means wholly convinced that this new method of training was good. Again we must exempt the nursing staff of the hospital. Throughout the demonstration the staff nurses gave their wholehearted support. Nurses as a whole, however, have not been strong supporters. One Windsor, physician, who approves the project, remarked that he was continually amazed by the opposition displayed by nurses to whom he talked. This attitude was by no means peculiar to Windsor.

3. A very serious problem, and a cause of great regret and anxiety, is our failure to convince the medical profession in Windsor of the wisdom and usefulness of our plan. Unfortunately, we never, at any time, had a chance to discuss the matter with them all together.

4. We did not arouse enough public interest in Windsor. Various individuals condemned either (or both) the care they themselves had received as patients and the traditional nurses' training. But we failed to interest any group sufficiently for them to examine our program or to understand that the Canadian Nurses' Association itself (and not the government or the Red Cross) was conducting this school. We feel that all too few people in Windsor, or indeed in Canada, understood our purpose, our philosophy, or our motive.

5. Finally, the school has not been continued. It is tempting to say that the only reason for this is the financial one; but of course this is not a sufficient reason. Money is found for what is really wanted.

### What Would We Do Differently Another Time?

While to some extent this must be conjecture, our experience has raised certain questions:

1. If the school were again to be set up in close association with a particular hospital, would it be better that this should not be a hospital conducted by a municipal government? A board made up of people, a large proportion of whom are there not primarily because of their interest in the hospital but because their political office puts them there, and which is, therefore, constantly changing, was in our case, and *might* always be, a difficult board with whom to establish a stable working relationship. But while an unstable board was without question a very real problem, was it the whole problem? All hospital boards are short of money and the idea that one person can be a student and an employee at the same time dies hard.

Naturally then the thought arose that it would be desirable to have no financial tie-up of any kind with the hospital, since apparently it continually confused thinking about training and service. At least for an experimental school, a completely central school, with no contract except for ward practice and that with a number of hospitals, is, we think, the desirable form of organization.

This principle of no financial commitment would, of course, have to work both ways. No payment would be asked by the school for the ward practice of the students. Experience has shown that a charge for student practice inevitably leads to an undue interest on the hospital's part in the amount of time spent on the wards by the students. Even though the student is nursing an average of more than half a nurse's day and the value put on her service is only a tenth of the cost of that nurse's day, and the number of nurses employed has been reduced, the hospital still feels that it should be getting more student service, especially at night. Also, the school wants and needs practice in the hospital wards and this involves some administrative planning on the part of the nursing service. Therefore, we feel that in a school organized so that the student is not "working her passage" it would be better to drop the request for payment for student service.

Such a central school as we suggest would have other advantages than that of freedom from financial bickering. It would permit a larger group of students,

a wider range of clinical facilties, and more economical use of a group of well qualified teachers. This last is important because the shortage of instructors is probably the greatest of all the nursing shortages.

2. In the Metropolitan School the student was provided with full maintenance without cost to herself. Would we advise this again? If the student's status as a student is really protected, is there any reason why she should not pay a moderate sum for maintenance? It may be asked whether recruits could be secured under such conditions. There is definite evidence that a certain number at least could be. Students, though so far not in large numbers, do come into longer and more expensive university nursing courses. Students of the last class at the Metropolitan School were asked if it would have been possible for them to come, and if they would have come, if there had been a charge for maintenance. The majority said that they would still have come. From time to time we have wondered if the psychological effect of having so much provided free was altogether good.

3. Should the school have had more publicity? Suggestions to this effect have been made occasionally and, as has been indicated above, we felt that we did not "sell" the C.N.A.'s program, philosophy or purpose to the general public or even to the citizens of Windsor. At the meeting at which the school was first approved in principle, representatives of all the Red Cross divisions and of all the provincial nurses' associations were present and agreed to give the demonstration publicity on returning home. When the school opened the Canadian press gave it publicity and the press in Windsor and several other papers published several very full articles, which were quite widely copied. That is to say, we seem to have had good advance and early publicity; and at all times we have had more applicants than we could accept. Whether planned, sustained publicity would have been an advantage is not known.

4. There remains one matter about which we have no doubt. In a nursing course the clinical experience and teaching are an important part of the course—no more and no less important than the theory. Planning for the curriculum should include careful preliminary preparation of the clinical fields, including seeing that the hospital and the various groups concerned understand what is proposed and what they are undertaking. There should be assurance that the nursing supplies are adequate and the techniques practised are as good as is humanly possible. There should be as many staff nurses as possible who have had the post-basic training for ward management or clinical supervision in various departments now generally considered desirable, if not essential, for posts of responsibility. Obviously, students should learn in a situation where good nursing is known and practised—and in saying this we are not speaking of "luxury" nursing. We fully realize that in Canada at present, because of the shortage of nurses, it is not possible to give all patients the finest individualized nursing care. Nevertheless, a student should learn good nursing before being placed in the position where she must use her judgment as to what must be omitted in order to cover the necessary ground.

### Conclusion

Although there have been serious problems, and although at times we have been discouraged, we of the staff feel now that the effort was very worthwhile. Whatever the formal investigation may say, we have a sense of great accomplishment. We think we did show that good nurses can be produced in two years, we are proud of our students, we are pleased with their health record. We know that they love nursing and that 40 of the 45 graduates are nursing or taking post-graduate work to-day.

We are grateful to many people and institutions: first, to the Metropolitan Hospital and the other affiliating hospitals—The Hôtel-Dieu, Windsor; the Hospital for Sick Children, Toronto; the Ontario Hospital, London; and the Essex County Sanatorium, Windsor, because a practice field was our first necessity; to the nursing staff of the hospital for their encouragement, co-operation, and support; to the Red Cross and the Ontario Department of Health for funds; to many people in Windsor for their friendship and assistance; to the many members of the medical profession who provided medical teaching and who cared for our students' health, particularly to: Dr. M. S. Douglas, Dr. W. H. Asselstine, Dr. F. R. Guest, Dr. A. T. Wachna, Dr. George White, Dr. Henri Breault, Dr. William Taylor, Dr. Gordon Campbell, Dr. Norman McCormick, Dr. J. H. Maus, Dr. B. Luborsky, Dr. Stuart Young; as well as to individuals too countless to name who have planned, worked, encouraged and assisted us and, in particular, to: Dr. Stuart Stanbury, Miss E. Kathleen Russell, Dr. Muriel Uprichard, Misses Agnes Macleod, Ethel Cryderman, Helen McArthur, Edith Dick, Gertrude Hall, Katherine Faville and the staff of the College of Nursing, Wayne University, Mildred Tuttle of the Kellogg Foundation, Miss Jean Masten, Miss Alma Reid, Dr. Kenneth Gray, Miss Margaret Kerr, Miss Rahno Beamish.

We hope that the formal report of the Canadian Nurses' Association and the Canadian Education Association will arouse much interest among nurses and the general public. We hope that others will be inspired to take up, continue, and expand our work. We hope that it will have contributed to the improvement of nursing training and practice and thus to the health of the people of Canada.

*May 12, 1952*

Nettie Fidler
Eleanor Martin
Margaret McPhedran





# Demonstration School Administration Committee

### Introduction

As the Metropolitan School of Nursing conducted by the Canadian Nurses' Association, under the sponsorship of the Canadian Red Cross Society, graduated its last class of students on September 13, 1952, the function for which the Demonstration School Administration Committee was established ceased to exist. The contract with the Windsor Metropolitan Hospital terminated on October 15, 1952.

During the six years since the C.N.A. received the support of the Canadian Red Cross Society to conduct a demonstration, independent school, the Demonstration School Administration Committee has acted on behalf of the C.N.A. in all matters concerning the demonstration school, in cooperation with the director and the Board of Directors of the Metropolitan School of Nursing.

Two outstanding reports have been prepared about the Metropolitan School of Nursing. One is the "Report of the Evaluation of the Metropolitan School of Nursing," prepared by Dr. A. R. Lord, and now published under the sponsorship of a joint committee of the Canadian Education Association and the Canadian Nurses' Association. The other is the "Report of the Metropolitan School of Nursing," prepared by Miss Nettie D. Fidler, the first director of the school. This latter report, published in this issue of *The Canadian Nurse*, tells the story of the school's development and problems during the demonstration period—January, 1948, to September, 1952.

Therefore, in submitting this, the final report of the Demonstration School Administration Committee, it is not our intention to include many details but merely to give a résumé of the type of problems dealt with by the committee and indicate the part the membership of the C.N.A. took in this nursing education project.

### First Steps

On December 6, 1946, at the meeting of the C.N.A. Executive Committee, held in Calgary, Miss E. K. Russell outlined the plans for the demonstration of an independent school of nursing, which had been approved by the Canadian Red Cross Society, and resulted in the grant of $160,000 to the C.N.A., providing a suitable hospital could be found for its location and a well qualified director appointed.

The chairman of the Educational Policy Committee was requested to convene a special joint committee, to be known as the Demonstration School Administration Committee, the membership of which should also include the three Red Cross Society representatives, as requested in the plan, as well as the members of the Educational Policy Committee.

The first item of business of the newly-constituted committee was to request the executive members of the provincial associations present to suggest the names of hospitals in their provinces that they considered would be suitable sites for the demonstration school. They were also requested to suggest names of nurses considered qualified for the position of director.

A small sub-committee was appointed to review the suggestions and the resultant recommendation, sent to the C.N.A. sub-executive for action, proposed that Miss Fidler be appointed to the position of director and that she be requested to visit certain hospitals, interview hospital boards, and report to the Demonstration School Administration Committee before any decision was made concerning the location of the school. Miss Fidler accepted the position, visited 11 hospitals, and in all made 19 visits before the choice finally narrowed down to the Metropolitan Hospital in Windsor, Ontario.

### Details Concerning the Location

As both Miss Fidler, as director, and I, as chairman of this committee, have reported regularly to the Executive Committee and at the biennial meetings of the association, the reasons why Windsor was finally chosen are well known and are on record at National Office.

The representatives of the Metropolitan Hospital, with whom Miss Fidler made the first contact, were most enthusiastic about the school being located in Windsor. She presented the details of our requirements and eventually received a brief letter from the hospital superintendent, acting as secretary for the Board of Governors, acknowledging the proposals. Our experience has shown that we should probably have waited until a formal contract was signed; however, the urgency of starting the demonstration, and the enthusiasm and apparent willingness to work with us, on the part of the Windsor authorities, led us to accept their verbal assurances and, as the city proceeded to secure and remodel a house as temporary accommodation for the school, we did not press for a letter of agreement until later. Eventually, on the request of Miss Rae Chittick, then the president of the association, the secretary of the Board of Governors of the Metropolitan Hospital wrote, asking that we accept his letter as formal agreeemnt.

### Board of Directors

Immediately after Miss Fidler's arrival in Windsor, steps were taken to secure a good local committee, to be known as the "Board of Directors of the Metropolitan School of Nursing, Windsor." The purpose of this Board was:

1. To promote the best interests of the school of nursing in all business and financial matters (this to include the administration of the school funds).
2. To facilitate relationships with the Metropolitan Hospital.

A statement of constitution and by-laws concerning this Board was drawn up and is on record.

Since its establishment, this Board has given tremendous assistance to the director of the school and the individual members have always made the chairman and members of the Demonstration School Administration Committee very welcome at the school in Windsor. Frequently, the two groups have met together and, on occasion, have joined forces to discuss certain problems with representatives of the Metropolitan Hospital Board and the city solicitor. At times, it has been necessary to have a Canadian Nurses' Association legal adviser present at these discussions.





### Contracts

It is generally conceded that written contracts are important in any business arrangement. The Canadian Nurses' Association believed it important that the director of the Demonstration School should request the Metropolitan Hospital to sign an agreement which outlined the details each was willing to abide by.

The situation which developed in Windsor cannot wholly be attributed to the fact that a mutually agreeable contract was not signed in the beginning by the hospital board, as we requested. However, the unpleasantness which resulted was unfortunate after a local hospital investigation led to the appointment of a new hospital superintedent and a changed membership for the hospital board of governors. The new board repudiated the letter signed by the former hospital superintendent, in which he requested it be taken as the confirmation of the contract Miss Fidler had submitted in the first place. The result was that when the School Board claimed the payment of $200 per year, per student, in return for services rendered to the hospital, many hospital board members declared it was the first time they knew that the former hospital superintendent had agreed, for the hospital board, to the proposals made by the director of our school. Immediately the school was asked to agree to a new contract which omitted the item of payment.

Miss Ethel Cryderman, then president of the Canadian Nurses' Association, signed the second contract and the new school budget was curtailed by the amount of $200 per student per year. About the same time the domestic staff was unionized, thus requiring an increased budget to meet rising maintenance costs of the school.

### Committee Reorganization

The membership of the committee was changed when the association appointed Miss Evelyn Mallory as chairman of the Educational Policy Committee. Thereafter, the Canadian Nurses' Association members were also reduced to three, to act with the three Red Cross representatives, and the director of the school assumed the duties of secretary for the committee. This reduction in membership allowed meetings to be called more readily in Toronto or Windsor, on the request of the chairman or the director of the school. The function of the committee thus became more advisory and action was taken only when problems presented could not be handled locally by the director or the Board of Director of the Metropolitan School of Nursing.

### Business Dealt With

In general, the problems referred to the committee fell into one or other of the following categories: public relations; financial or legal implications; personnel or labor relations; faculty changes; arrangements for evaluation and termination of the demonstration.

The most frequent problems dealt with, however, had financial or legal implications. At times the chairman and members of the committee have interviewed both federal and provincial officials, as well as met deputations from Windsor hospitals in the interests of the demonstration school. Before the location was decided, a group waited upon the Minister of National Health and Welfare with hospital board members from another city, in an attempt to secure financial assistance for their hospital to pay graduate nurses, as replacement for students, in the event of the demonstration school being located there. As this was the hospital having the oldest training school in Canada, many of the committee regretted it could not secure the necessary assistance at that time to enable the hospital to accept the Canadian Nurses' Association proposal.

The early recognition, on our part, that Windsor was in financial difficulties led us to make repeated visits to the Deputy Minister of Health and Welfare in order to secure early payment of grants-in-aid to the Metropolitan Hospital for the construction of the new residence and school building. Later, deputations, including the director of the school and Toronto members of the committee, requested financial assistance to enable the school to function until October 15, 1952, in order to allow the last class admitted to complete the full course, as the final payment of $20,000 from the Red Cross was received on May 31, 1951.

The understanding and cooperation on

the part of both the federal and provincial Departments of Health and Welfare have made it possible for the demonstration to be completed and the evaluation study conducted. Our great regret is that the Metropolitan Hospital Board and the Metropolitan School, as conducted by the Canadian Nurses' Association, together were unable to make a united approach for continuing government support. We are very grateful for the financial assistance we have had.

### School Faculty

Following Miss Fidler's appointment as the director of the school, steps were taken to secure other faculty members. By the time the school opened in the house provided by the city as temporary quarters, Miss Eleanor Martin had arrived, Miss Eleanor Graham and Miss Margaret McPhedran being appointed shortly afterwards.

Other instructors joined the staff from time to time, following Miss Graham's resignation to return to British Columbia. Latterly one or two of the school's graduates have served as relief clinical instructor.

In the autumn of 1951, Miss E. K. Russell retired as director of the University of Toronto School of Nursing and Miss Fidler was asked to succeed her. Unfortunate as this was for our school, we nevertheless were glad for her. She resigned as director, effective January 1, 1952. Miss Martin, the assistant director, was moved up to the position of director and Miss McPhedran to the position of assistant director. Miss Wilma Peterson joined the staff as clinical instructor.

The Demonstration School Administration Committee fully realizes how much time and effort has been spent by Miss Fidler and each member of the faculty. The students were most fortunate in the calibre of teaching and supervision they have received and it is to the school faculty that the Canadian Nurses' Association is so greatly indebted for their loyalty and continued services to the demonstration project. Our best wishes go with each of them to their next endeavor and also to each student who graduated from the Metropolitan School of Nursing during the years 1950-52. The committee members will follow their professional careers with interest.

### Termination of Demonstration

Final meetings of the Demonstration School Administration Committee and the Board of Directors of the Metropolitan School of Nursing have now been held. As of September 30, 1952, the records of the school have closed and, with the auditors' financial statement, have been sent to the National Office of the C.N.A. The school building was made ready for official transfer to the Metropolitan Hospital on October 15, 1952.

### Conclusion

The administration of the demonstration school presented numerous problems, many of which were to be expected in a project of this type. Canadian nurses generally regret the necessity for its discontinuance. Yet there is among the members of this committee a feeling of great satisfaction. Each considers it has been a real privilege to have participated in this piece of pioneer work in the field of nursing education.

In concluding the business of this committee the following resolution was incorporated into the minutes:

> Whereas, It appears to be generally conceded that the program of the demonstration school has succeeded in producing adequate nurses in the shortened period, and
>
> Whereas, It is our conviction that this program can only be carried out when the school is "independent" (i.e., has an income and is able to plan the time of its students), and
>
> Whereas, The Canadian Nurses' Association is on record as approving government support of nursing education, such as is given to other fields of education, therefore be it
>
> *Resolved,* That the Canadian Nurses' Association make every effort to induce governments to make possible larger programs embodying the principles of the demonstration school.

Agnes J. Macleod
*Chairman*

Nothing will ever be attempted if all possible objections must first be overcome.
—Samuel Johnson.



# Plan and Methodology of the Head Nurse Study

Gordon H. Josie

My part in this discussion is to tell you about the plan and methodology of the study. In case this sounds very dull, may I remind you that Florence Nightingale was an early proponent of the use of statistics.

You have all heard talk about the shortage of nurses in Canada. The Canadian Nurses' Association and the Department of National Health and Welfare were interested in an approach to the problem by considering possibilities for the most effective use of our limited nurse resources. This study is part of the attack on that problem.

We already knew something about the distribution of nurses in Canada—how many were working at their profession; whether they were in hospitals or private duty work. But to complete the picture we needed to find out just how the nurse's time on duty is spent. How much time does she devote to various kinds of activities? How often does she do certain things? Does she do some more than others? Is she performing any duties of which she could be relieved?

It would have been quite an undertaking to study all nursing positions. After careful consideration it was decided to begin by taking a close look at the activities of the head nurse. You may wonder why we chose the head nurse. First of all, we knew that more than half of the employed graduate nurses work in hospitals and the proportion is increasing. We knew that the head nurse is a key person in the hospital organization.

Like every hospital employee the head nurse is not working in isolation. Hers is a particularly strategic position. In addition to her contact with the patients, her activities touch a great many other professional people as well as the general hospital staff. A picture of her work will incidentally give some view of the work of her colleagues.

We thought a study of the functions of the head nurse should throw some light on whether or not we are making the most effective use of our nursing resources. This is not a perfect world. And no doubt here, as elsewhere, improvements can be made.

I'm sure some of you are head nurses. You are probably thinking you could answer the question of what the head nurse does. But if each of you were to write down your idea of the matter, I think it would be a fair guess that we'd have as many different versions of her functions as there are people in this room. That is to be expected because each one of you would be looking at the picture from a different vantage point.

That brings me to the crux of the matter. In order to get a true and unbiased picture of the work the head nurse does, it was necessary to design a scientific experiment. The problem was to work out a method of catching an overall view, so to speak, of the head nurses at work. This required a good deal of thought and planning, for there were many factors to be considered. Before we could begin to work out our plan we had to consider what questions must be answered. To get an adequate account of the functions of the head nurse we need to know the time, the place, the persons, and the equipment involved.

Having decided what we wanted to know, we proceeded to set up a method for observing and recording the information. Who should be the observers? What head nurses should they watch and when? For how long at a time?

You may think we could choose a "typical" or average head nurse and follow her around on her duties. But the statistician has learned that such notions

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cannot be trusted. Section of a "typical" example is difficult if not impossible. And it's almost sure to be biased. As a character in *Punch* observed, "It's my belief that there ain't more than one average woman in fifty."

We decided to observe all the head nurses (15), excepting those in maternity wards, operating rooms, and the outpatient department. These have somewhat different and specialized functions.

We set about designing a schedule of observations that would meet certain criteria laid down in advance. Most of these were, of course, basic to our purpose, but some were based on practical considerations.

For example, we chose the Ottawa Civic Hospital as the locale of the study partly because of its convenient location. There were other reasons for choosing it, too. It is a large, general hospital. Most important of all was the fact that both Dr. Piercey, the superintendent, and Miss Young, the director of nursing, were interested in the project and willing to cooperate. (They have been most helpful to the research group throughout the investigation which must have been upsetting for them at times). Miss Young will be telling you what a nuisance we were!

As you may guess, it turned out to be impractical with our resources to make a complete record of one head nurse's activities for even one full day. They are so much on the go. The observers couldn't take it! Yet we wanted to be sure to cover all the duties that a head nurse performs and our composite picture was to include or represent the full 12-hour hospital day. By limiting the observation periods to one hour we avoided fatigue in the observers—perhaps in the observed, too. This also made it possible to cover a greater length of time.

We chose a team of four observers. They were equipped with stop-watches and record forms designed to allow for precise and concise notes of activities and related places, persons, and equipment, timed to the nearest quarter minute. This resulted in 120 one-hour records accounting for 28,800 intervals of 15 seconds' duration.

Each head nurse was observed for eight one-hour periods. These eight periods were arranged to represent the full 12-hour day. Each of our four observers watched each head nurse for two periods. Of course, the head nurses were aware of being observed but they did not know in advance that they were going to be as the periods were at irregular intervals.

Most important of all, the periods and the observers were randomly distributed over the ten days. Random distribution is not a haphazard arrangement as is commonly thought. Rather, it's a procedure to ensure that every member of the population has the same chance of being selected. This can be done by drawing number out of a hat, marbles out of a jar, etc. But for our purpose it was conveniently done by using tables of random numbers. This device enables us to get an idea of the confidence we can attach to our estimates and we will have unbiased estimates.

So in the activity records we are dealing with a sample of head nurse activities laid out on a schedule of observations carefully planned with regard to the variables—observers, head nurses, and time of day. The observers were given instructions to carry out the schedule *exactly* to the fullest extent practicable.

When our observers returned with their sheaves of material—720 pages of field records—we started the job of analysis. We had, of course, already made considerable progress with our classification schemes. We had reviewed the Johns and Pfefferkorn work on activities of nurses and the U.S. Public Health Service "Head Nurse Study in the Massachusetts General Hospital," also other authoritative statements on nursing functions. In fact, we had pretty well steeped ourselves in the nursing business. But we found no system adequate for our purpose. We set out to develop detailed, specific, and mutually exclusive categories with clear-cut boundaries of classification fields. It was heavy going but this turned out to be an especially interesting and valuable part of the project.

In our classification the functions and activities carried on by head nurses were grouped in the three main areas: (1) patient care; (2) ward administration or housekeeping (all non-nursing); (3) personnel administration.





We found that the activities in each of these three areas fell into what we have called *levels of function*. There are five: (1) management; (2) supervision; (3) direction; (4) education; (5) execution (we used this word for want of a better one to describe direct personal action by the head nurse).

Perhaps I could make this classification system come alive by giving you a few examples. For instance, under "Patient Care—Management" a major activity is P.121—planning with the medical staff for the care of patients. And under "Patient Care—Execution" we have such activities as P.501—observing and recognizing general symptoms and conditions.

After setting up our classification system which ran to some 290 specific activities, each was reduced to a code number which identified the activity and indicated its area and level. This system is necessary for actual tabulation of the information. The coding and analysis of the data has been carried out, so far, largely on the basis of the major classification groups. You would be disappointed if, after all this talk, I did not produce a few numbers.

Our preliminary data has already shown that for nearly a quarter of the time that the head nurses were being observed they were dealing with the nursing staff in one way or another. Their contact with the medical staff accounted for another 11 per cent. For about a third of the time the head nurses were alone or at least operating independently.

We found, too, that the head nurses were at the nursing station about 60 per cent of the time and in patients' rooms and wards for about a quarter of the time. Some of you may think the head nurse spends all her time telling other people what to do. That turns out not to be the case. Actually, two-thirds of her time was found to be spent in activities we classed as "execution." That meant that she was doing the job (including paper work) herself. Managerial activities took up only 6 per cent of her time.

Detailed analysis of the activities, taking into account the factors associated with them, and the variables (wards, time of day, etc.), is quite complex, as you may imagine. We have found it necessary to use a marginally punched card system. We have a card for each activity. There will be about 12,000 cards. This phase of the analysis is well under way.

What about future research projects? There are various alternatives. We can study the head nurse situation in other hospitals or can turn our attention to other members of the nursing staff. I anticipate that our data will throw some light on the most fruitful field to explore.

I must emphasize, though, the magnitude of undertakings like this. By way of illustration, you might like to know that this study has required a director and a research assistant for over nine months and one to three clerks for a similar period.

For any study comparable to this you would need the services of two statistical clerks, full-time, for a minimum of six months; a qualified research worker for the same period; and a research director available throughout and devoting the major portion of his time to the project for three to six months.

In conclusion, I would like to say we already are convinced that our method is producing comprehensive data of the kind needed to answer our basic question, "What does the head nurse do?" Further, the classifications and codes we have prepared for activities and the related factors form an essential part of the methodology of projects of this type. We have prepared an interim report on the study with some simple charts to illustrate the sort of data we are getting.

I would like to acknowledge the continued cooperation of the Ottawa Civic Hospital, particularly Miss Young, the director of nursing. We want to express our appreciation also to Mrs. Thomson and Mrs. Edgar of the nursing administration staff who served as observers throughout. To the head nurses who endured the close scrutiny of our observers, a special word of thanks.

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Liberty is not a form of government. It is the heart of free man; he carries it with him everywhere.—ROUSSEAU.

# Nursing Profiles

Catherine Wilson Perkins has joined the staff of *The Canadian Nurse* as assistant editor and field representative. The latter responsibility will take her out among the nurses of Canada in their own communities where she will endeavor to satisfy nurses' desires for the latest information on a wide range of nursing topics.

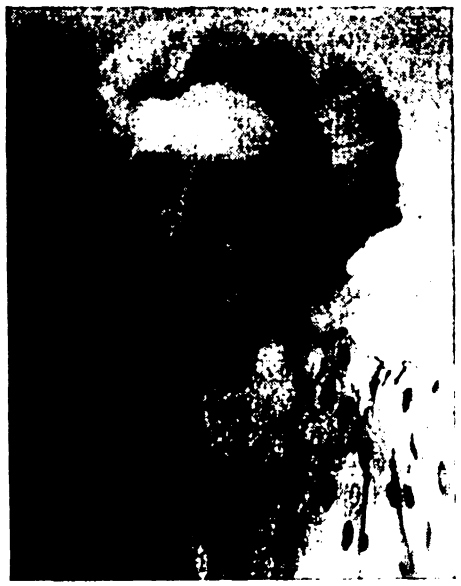
Born in England, Miss Perkins moved to Canada with her family as a child and received her education in Humboldt, Sask. A graduate of the school of nursing in Maple Creek, Sask., she spent nine years there as assistant director of nursing before enrolling in the public health nursing course at the University of British Columbia. Miss Perkins was in charge of health services with the Children's Aid Society in Vancouver for a year before joining the R.C.A.M.C. She served overseas with the No. 8, C.G.H., in England, France, Belgium, and Holland. On her return to Canada she qualified in supervision in public health nursing at the McGill School for Graduate Nurses before becoming an assistant supervisor with the Metropolitan Health Committee in Vancouver. Latterly, she has been supervisor with the city health department in Victoria. She received her degree—Bachelor of Science in Nursing—from the University of Washington this year.

*Knight, Victoria*

CATHERINE PERKINS

Florence Isabel Greenaway has been appointed associate director and lecturer in nursing on the faculty of McMaster University School of Nursing, Hamilton, Ont. She succeeds Marjorie (Pinchbeck) Campbell on the faculty and will be in charge of the public health nursing program.

Born and educated in Guelph, Ont., Miss Greenaway graduated from Toronto Western Hospital. She holds her Bachelor of Nursing degree from the McGill School for Graduate Nurses and her Master of Science in Nursing secured at Wayne University, Detroit. For several years following graduation, Miss Greenaway engaged in private and general staff nursing. She joined the staff of the Victorian Order of Nurses in 1936 and later served as nurse in charge at Timmins, Ont., and Saint John, N.B. More recently she was a regional supervisor with the Ontario Department of Health serving in southwestern Ontario.



FLORENCE I. GREENAWAY

Christine MacArthur is active as a National Office supervisor of the Victorian Order of Nurses, functioning in northern and central Ontario. A graduate of Toronto Western Hospital, Miss MacArthur holds her certificate in public health nursing from the University of Toronto School of Nursing and also her B.S. degree from Teachers College, Columbia University. Previously she has worked on the V.O.N. staff in Toronto and Fredericton, was nurse in charge of the Sudbury and Huntsville (Ont.) branches and, prior to her present appointment, was assistant to the district superintendent in Winnipeg.

CHRISTINE MACARTHUR

Ruth Webster is now the director of nursing education at St. Andrew's Hospital, Midland, Ont. A graduate of Hamilton General Hospital, Miss Webster has worked as night superintendent at the Royal Victoria Hospital, Barrie, Ont., and assistant supervisor and clinical instructor at Women's College Hospital in Toronto.

Mary Shand has retired from the staff of the Burnaby (B.C.) Health Unit after serving as supervisor of the unit since 1938.

Miss Shand came to this position with a wealth of experience behind her. She graduated from the Vancouver General Hospital in 1915 and was a head nurse in that institution until she joined the Canadian Army Medical Corps with which she served overseas for two years. On her return she was appointed supervisor of the Isolation Hospital of the Vancouver General where she remained until she became a nursing sister with the Soldiers' Civil Re-establishment Hospital in Victoria. The building of the Dry Dock at Esquimalt did away with this hospital and Miss Shand, thinking the American fields looked green, left Canada in 1921 to work in the Stanford Hospital in San Francisco. A period of private nursing followed as well as several months at the San Mateo Preventorium. However, two years away was sufficient and, in 1923, Miss Shand joined the admitting office staff of the Vancouver General Hospital. Then she attended the University of British Columbia and obtained her certificate in public health nursing. She accepted a position with the Victorian Order of Nurses and was posted to Windsor, Ont. Back in British Columbia again, Miss Shand became superintendent of the King's Daughters Hospital in Duncan but, as her primary interest was in public health nursing, she returned to the V.O.N., this time to work in Burnaby.

Miss Shand was one of the two nurses appointed to the Burnaby School Board. In the summer of 1938 Burnaby joined the Metropolitan Health Committee. During her 14 years of service in Burnaby, she has seen that municipality double in population and the school enrolment increase from 5,000 to nearly 9,000. The nursing staff has grown from four to ten members.

Over all these years of service, Mary Shand has retained a freshness of outlook and a cheerfulness of heart that has endeared her to all with whom she comes in contact. Her gracious manner and friendly hospitality has made the Burnaby Health Unit a happy place to work.

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There is on the whole too strong and too widespread a tendency to be complacent about the educational system and to point with pride to the large percentage of adolescents and young adults enrolled in high schools and colleges. A glance at the mortality, or elimination figures, should give us pause and warn against confusing quality and quantity. The dilution of curricula and courses, both in high schools and in colleges, and the expansion of systems of counselling and guidance seem to have done little to reduce the high percentage of waste incurred at a financial sacrifice by the nation and to the psychological detriment of the students themselves.

—*School and Society.*

*Institutional Nursing*

# Radio-Active Isotopes in Medicine and Research

DAVID TURNER

This material is not meant for nuclear-physicists. It is not meant to scratch more than the surface of the mass of knowledge that is fast accumulating on the subject of radio-active isotopes. The purpose of this article is merely to familiarize the personnel, who will be associated in any way with the administration of radio-active materials as a therapeutic tool in medicine, with some of the fundamental concepts of radio-activity; precautionary measures to be employed in handing radio-active material and the patients who have been treated with radio-active isotopes; and finally to point out the indications or the diseases which are now being treated with the isotopes.

The whole subject of radio-active isotopes in therapy is a newborn child that is fast developing and what I say today may be completely erroneous tomorrow. Most of the therapeutic trials are still to be considered in the experimental stage. Some are at the point of being past this stage such as radio-active iodine and radio-active phosphorus which have been used widely for some time.

For convenience, I have divided the material into two parts—the first to deal with general theory and the application of the isotopes in therapy and the second to discuss the more important use of the isotopes at the present, as tracer substances in modern research.

## WHAT IS AN ATOM

Let us consider the atom as a system having a central nucleus made of two constituents called protons and neutrons. The protons carry a positive electrical charge and the neutrons carry no charge. They are neutral—hence the name. The protons and neutrons have, for our purpose, equal masses—that is, they have the same weight—and the total weight or the mass of an atom is actually the total combined weight of the protons and neutrons. Around the central nucleus of the atom there are one or more orbits or paths, followed by infinitely small particulate matter called electrons. The electrons are negatively charged. They exist in a sufficient amount to exactly neutralize the number of positive charges contained in the nucleus as protons. The relationship of electrons can be described as being similar to the solar system with the various planets and the sun, the earth and the moon revolving about one another in fixed paths, determined in great part by the attraction of one body for another.

The mass or weight of an atom is, therefore, determined by the number of protons and neutrons in its nucleus. The chemical properties are determined by the configuration of the atom with respect to the electrons which, for all intents and purposes, have no mass.

When the number of protons in the nucleus is exactly equal to the number of electrons in the orbits, that is when the positive charges exactly equal the negative charges, then the element which is made up of the atoms is called a stable element. Atoms make up molecules, molecules make up the elements. Most of the elements found in nature are stable elements. Occasionally certain substances have the same electron configuration and yet have a slight different mass because of an added neutron which does not actually disturb the stability of the atom since the neutron has no charge. However, because the electrons are the same, the atoms will have similar chemical properties and are called isotopes—*iso,* meaning equal. For example, there are stable isotopes of chlorine which have a respective mass of 35 and of 37—carbon has atoms of mass 12 and 13—sulphur has the isotopes with masses 32, 33, 34, 36, and so on.

As a fellow in biochemistry and research assistant in medicine at the University of Western Ontario, Mr. Turner gave this material as a lecture to the students at Victoria Hospital, London, Ont.

## RADIO ACTIVITY

What actually then is radio-activity? Always remember that matter is held together with a tremendous quantity of energy. The quantity is of an order which the layman cannot ordinarily fathom—it is often of the order of millions of volts. When the stability of the atom is disturbed by any means then the atom tends to attempt to re-establish its stability and in so doing it releases energy in the form of rays. These are the rays of radio-activity. In nature only the uranium and thorium series are radio-active. The rays emitted by radio-active materials have a destructive effect on tissue by virtue of ionization of constituent portions of tissue—that is, they break up molecules of tissue. It is this property which makes the radio-active isotopes both useful in therapy and also dangerous to handle.

Radio-active isotopes have been used for 15 years but only in very small experimental quantities. The advent of the cyclotrons and the chain-reacting atomic piles, which were built primarily for production of the atom bomb, changed this. Now they are being used primarily for the production of artificial radio-active isotopes for use in medicine, industry, and basic research. The basis of production of artificial radio-active isotopes is the bombardment of stable isotopes with neutrons, protons, or other particles so that one of the particles enters the nucleus of the atom or knocks out one of the constituents present, thereby upsetting the equilibrim of the atom, the result being the emission of rays which are ordinarily of three orders:

*alpha rays*—which pentrate a distance of a fraction of a millimeter.

*beta rays*—which penetrate one millimeter.

*gamma rays*—which penetrate a distance of inches and feet.

## DISINTEGRATION

The substances emitting the rays disintegrate at a constant rate and in a constant pattern. Each has its own particular length of time of disintegration for it to reach stability. We often refer to the half-life of a substance, which actually means the time necessary for the emissions to be half dissipated. For example, the half-life of Radio-active Iodine ($I^{131}$) is 8 days. Therefore at the end of 8 days half of it will be gone. After another 8 days only one quarter of it will be left and in another 8 days only an $1/8$ will remain. Phosphorus has a half-life of 14.3 days, gold a half-life of 2.3 days, cobalt 5.3 years.

The emissions are measured in terms of the number of disintegrations per second so that when you hear the physicist talking of so many "curies" he means $3.7 \times 10^{7}$ disintegrations per sec. A millicurie is 1/1,000 of a curie and a microcurie 1/1,000 part of a millicurie.

## TRACER SUBSTANCES

The greatest contribution that the radio-active isotopes have made to the advancement of human knowledge in medicine has been due to their use of tracer substances in metabolic processes in the body. A substance known to take part in metabolism is "tagged" by the addition of a small quantity of its radio-active analogue and its movements can thereafter be followed by means of a suitable detecting instrument, usually one of the forms of Geiger counter. Notable advances, for example, have been made by such means in the study of uptake, distribution, and excretion of many elements, in the determination of the permeability of the phase boundaries of the body, and in the examination of the life history of red blood corpuscles.

These procedures, however, belong to the research laboratory. It is the clinical applications of radio-active isotopes that we wish particularly to discuss—those in which use is made of the radiation to investigate and treat disease. By their very nature these materials, particularly in the high activities demanded by their use for therapeutic purposes, are potentially dan-

gerous to patient, doctor, and nurse alike. They should be used only by those who have a sound knowledge of the physics of radiation and the biological effect of ionizing radiation on man. The problems of protection from radiation, disposal of excreta, and general prevention of contamination can be solved only with the aid of a properly equipped physico-chemico department.

In general, the longer the half-life the greater the danger; the injudicious use of such agents, especially in young patients, may produce effects which are no less unpleasant because they are delayed.

### Application

The thyroid gland's avidity for iodine, which is embodied in the thyroid hormone, has provided the basis for a great volume of work with $I^{131}$ designed to clarify our knowledge of thyroid metabolism and to help us distinguish the normal from the abnormal. An extension of technique, using a shielded Geiger counter, has made it possible to measure the anatomical extent of the iodine-containing tissues and thus provide a useful diagnostic aid in cases of retrosternal masses of doubtful origin. Still further, much work has been done on the $I^{131}$ uptake in thyroid carcinoma and it has been found that a small proportion of such tumors do, in fact, compare with the normal gland in the way they take up iodine. Metastases may behave in the same way but, if they do not, some may be induced to do so by first removing all the normal thyroid tissue so as to encourage the metastases to take over thyroid function. The detection and localization of brain tumors have been attempted using $I^{131}$ in diiodofluorescein.

$P^{32}$ has been used for the same purpose but can be used only with craniotomy as its radiations will not penetrate the cranium.

$S^{24}$ has been used in the measurement of circulation time and in the localization of the placenta. The labelling of red blood cells with $P^{32}$ to measure the volume of circulating blood has enabled this to be done with an accuracy not achieved before.

### Therapeutic Uses

*Replacement for interstitial radium:* Cobalt 60 and Tantalum 182 are made into beads, wire, and foil which have a greater flexibility than radium and are cheaper.

*Surface and intracavitary irradiator:* Co. 60 and Ta. 182 are made into mesh or foil and used as gamma ray surface applicators. $P^{32}$ solution soaked up by blotting paper or in plastic sheeting and used as beta ray applicators—for the treatment of superficial lesions of the skin and mucosa.

Gold 198 (colloidal suspension) for peritoneal spread of carcinoma is injected in the peritoneal space. Molecules are large enough so no absorption of gold takes place through the peritoneal membrane. Following therapy there is regression of carcinomatosis with suppression of formation of ascitic fluid. This is merely a palliative procedure.

*Superficial carcinomata of bladder:* Co.60, Na.24, and Bromine 82 are used in solutions of suitable radio-active salts which are placed in a rubber bag and introduced into the bladder. Treatment is short. Discomfort is not great. Early results are achieved.

*Direct infiltration of tumors:* Infiltration with volume of colloidal suspension Au. 198 solution remains in the tumor long enough to provide a very great number of effective point sources of radiation.

$P^{32}$ (1) Polycythemia veta (Osler's disease)—Here there is treatment of choice; 5 mc. initially, 5 mc. in 6 weeks.

(2) Used in chronic leukemia since lymphocytes and granulocytes pick it up. The patient's life is not lengthened but he is able to continue normally until the last two or three weeks and transfusions are not usually necessary.

(3) Acute leukemia—*no value*. Strontium is used in eye ulcers.

*Summary:* Rapidly growing tissues pick up radio-active material in greater quantity than normal tissue. In carcinoma a million tiny sources of radiation accumulate within the cells of the tumor to irradiate each malignant cell from within. Unfortunately, in certain cases, an effective dose to destroy the malignant tissue would also destroy the host.

### Precautions

1. Radio-active isotopes should not be handled by persons with cuts or open wounds on the skin. In case of puncture of the skin with an object contaminated with radio-active isotopes, flush with cold water within 15 seconds and scrub with soap and brush. If enough of a dangerous isotope is contained in the wound, a tourniquet may be placed on the arm and a surgeon excise the contaminated tissue but thorough washing will usually be sufficient.

2. No pipetting of radio-active materials by mouth.

3 Rubber gloves to be used at all times.

4. Remote control tongs to handle beta and gamma emitters or equipment containing or contaminated with them.

5. Masks to be worn where dust may be radio-active.

6. Spread of radio-active contamination throughout the laboratories, operating rooms, wards, and the institution in general, must be prevented.

7. Tables on which radio-active materials are placed, whether in the laboratory or the operating rooms, should be covered with sheets of blotting paper to absorb any spilled fluids.

8. Adequate lead-lined receptacles must be available for the disposal of waste materials, contaminated gloves, beakers, syringes.

9. In certain cases, protective clothing, differentiated from normal clothing, should be worn and monitored before being sent to the laundry.

10. There shall be no eating or smoking in regions of radio-activity because of the danger of ingestion of isotopes which is the worst hazard.

11. Where a great deal of radio-active material is being used on a ward, the personnel should be rotated so that the exposure is distributed. Accumulated exposure is a potential hazard.

12. Urine from patients given tracer doses of radio-active material need not be collected. However, where large doses of therapeutic isotopes are administered all excreta must be collected and placed in lead-lined receptacles until the radio-active material disintegrates.

13. All personnel should be equipped with personal monitoring meters for their protection when exposed to rays: (a) A pocket ionization chamber; (b) a film badge; (c) a ring badge (where hands are exposed).





## In the Good Old Days

*(The Canadian Nurse*—November 1912)

"The time given to the preliminary training of nurses varies greatly—from two or three weeks to six months—and the amount of theoretical study also varies considerably. . . The cost to hospitals of a good preliminary course is so considerable as to prevent its organization in many instances. It would appear to be desirable that such courses should be carried on by some special school in cooperation with several hospitals. . .By this means hospitals could be kept from working the preliminary pupil who should not be pushed into theoretical work and have hospital work required of her also."

* * *

At the I.C.N. Congress held in Cologne in 1912, the initial steps were taken for "the nurses of the world to cooperate in founding an educational memorial in memory of Miss Nightingale which would benefit the nurses of the world. . . Miss M. A. Snively expressed her complete sympathy with the proposition. She believed that such a memorial was one which Miss Nightingale would have approved. 'Pioneers pass, but leave behind them a world transformed out of the resemblance to that on which they opened their eyes.' "

* * *

"Sixty-eight nurses from many parts of British Columbia gathered at a meeting on September 10 for the purpose of organizing a provincial Graduate Nurses' Association. . . A committee was struck whose duty it will be to prepare a bill for presentation to the government at Victoria, seeking registration."

* * *

"This is the age of the child. Workers for social betterment everywhere realize that unless child life is conserved and properly developed, the degeneration of the race must result, and that spells decay and downfall for the nation."

*Aux Infirmières Canadiennes-Françaises*

# Un Aspect du Nursing Industriel

ALBERTINE MAILLOUX

J'ai intitulé mon sujet "Un Aspect du Nursing Industriel et ses Problèmes." J'ai puisé mes ressources, mes recherches, "chez-nous" d'abord—c'est-à-dire, là où j'exerce mes fonctions. J'ai aussi obtenu des renseignements utiles de quelques compagnes désireuses d'aider notre cause commune. Il va sans dire que tous les problèmes énumérés ne doivent pas être imputés à une usine en particulier. J'aurais alors tôt fait de déprécier mes employeurs et d'exploiter la confiance qu'ils me témoignent. Loin de moi cette idée. Ces problèmes sont ceux que nous retrouvons un peu partout dans une entreprise du même genre. En illustrant mon sujet de quelques exemples je désire ne pas prêter à l'équivoque.

Répétons avant d'entrer dans l'essence même du sujet qu'il y a une quarantaine d'années que l'infirmière a débuté dans l'industrie canadienne. Nous savons que son travail consistait alors à panser les blessures, que ses responsabilités étaient localisées aux premiers soins d'urgence. Quelques industries étendaient ses services à la famille des employés.

Nous savons aussi qu'aujourd'hui au Canada l'on compte approximativement mille infirmières industrielles. En Ontario les infirmières forment un groupe district. Dans Québec elles font partie de la Section d'Hygiène Publique.

Faisant suite au service familial du début du siècle, l'apparition de l'infirmière dans l'industrie eut d'abord pour but de diminuer les pertes d'argent causées par les accidents du travail mais les industriels réalisèrent vite l'importance d'étendre ses services au bien-être et à l'hygiène à cause de la perte d'argent subie par les maladies, faisant ainsi pénétrer la médecine dans la structure industrielle.

Par ces préliminaires, nous devinons facilement que le nursing industriel offre plusieurs aspects et que de sérieux problèmes découlent de cette organisation jeune mais déjà importante, non seulement au point de vue provincial mais aussi au point de vue national et même international.

L'aspect sous lequel je veux vous présenter est celui où l'infirmière travaille seule—c'est-à-dire, sans médecin spécialement attaché à l'usine et où le nombre d'ouvriers peut atteindre mille et même quinze cents. Ces problèmes ne sont pas ceux d'une infirmière exerçant ses activités sous la tutelle médicale ou secondée par une ou plusieurs compagnes. Toutefois, comme le nursing industriel se ressemble sous tous ses angles, l'infirmière industrielle,- quel- que soit son genre de travail, reconnaîtra certainement plus d'une fois, les mêmes images et les mêmes problèmes.

L'industrie moderne est un système par lequel les employés, les machines, les matériaux et l'argent sont employés pour apporter sur le marché des produits à bas prix, réalisant le plus de profits possibles aux organisateurs. Pour qu'il y ait efficacité il faut que tout soit bien coordonné.

L'administration d'une usine en elle-même n'entre pas dans la sphère de l'infirmière mais, en entrant dans l'industrie, l'infirmière fait partie du personnel, même si elle en est distincte par sa profession. Elle doit donc connaître tous les facteurs qui visent au succès de l'entreprise. Elle doit s'intéresser à tout ce qui se fait à l'usine, comme une infirmière dans un hôpital, une unité sanitaire ou dans tout autre service doit s'associer aux événements qui touchent ces organismes

Mlle Mailloux est infirmière industrielle à St. Jérôme, Qué.





et peuvent par le fait même modifier ses propres fonctions individuelles.

L'autorité administrative d'une industrie dépend de son importance. Dans le genre d'industrie dont il est question, il y a généralement un président, vice-président, gérant général, gérant du personnel, des surintendants, contremaîtres, contre-maîtresses, sous contre-maîtres. Le gérant général est habituellement le coordonnateur et voit à l'administration des départements, quoique ses attributs se confondent souvent avec ceux d'un surintendant, d'un gérant du personnel, etc.

L'infirmière doit dépendre autant que possible de la haute direction, afin de pourvoir discuter avec elle des problèmes à certaines intervalles. Cependant son contact le plus fréquent est avec le gérant du personnel qui embauche les employés et voit à la discipline. Elle doit aussi collaborer à tout instant avec les surintendants et contremaîtres. On insistera jamais trop sur la collaboration de l'infirmière avec tous les chefs de départements.

Les problèmes résultant de cette autorité sont complexes. Chaque chef de département assume l'autorité dans sa sphère et pourtant l'infirmière a besoin parfois de l'autorité supérieure pour atteindre ses fins qui doivent toujours viser l'intérêt général. Afin d'éviter tout conflit, le tact prend ici une grande importance. En recourant à un officier supérieur, elle ne doit jamais diminuer la valeur d'un sous-chef et vice-versa.

Il arrive parfois aussi que l'infirmière ne sache pas très bien de qui elle dépend parce que les rôles sont mal définis. Ces situations embarrassantes nuisent à l'efficacité et devraient être rétablies sans délai mais l'infirmière, malgré toute sa bonne volonté, doit parfois attendre longtemps le règlement de ces dispositions qui occasionnent des problèmes ou encore l'infirmière ne sera pas satisfaite si elle doit obéir à un représentant n'ayant pas autorité sur toute l'entreprise. Elle sentira là une insuffisance qui entravera son élan.

Il peut aussi y avoir de graves conséquences si l'administration donne à ses représentants juridiction sur le travail même de l'infirmière, lequel doit être sous la direction médicale (même s'il n'y a pas de médecin à l'usine).

Un moyen d'atténuer les difficultés dérivant de l'autorité est d'étudier les caractères des agents exécutifs afin de mieux les comprendre et agir avec condescendance même s'ils inspirent l'étroitesse, se souvenant de cette parole de Emerson, "Traitez les hommes avec grandeur, ils se montreront grands."

## SITUATION

Le département médical d'une usine doit être situé a un endroit facile d'accès d'où il est facile d'en sortir, j'entends, ou un taxi ou ambulance puisse s'approcher en case d'urgence. Il doit être bien éclairé, bien aéré et propre. Il sera spacieux ou plus petit selon l'importance de l'usine mais il peut fonctionner efficacement, en ne contenant que les articles essentiels sans luxe et sans spécialités, à plus forte raison s'il n'y a pas de médecin à l'usine.

Comme l'infirmière industrielle ne traite pas des malades mais plutôt des cas aigus d'indigestion, maux de tête, fatigue, la liste des médicaments employés est limitée. De même en est-il pour le traitement des plaies. Il est inutile d'avoir des désinfectants compliqués puisqu'il ne s'agit que de blessures sans gravité (les cas sérieux étant référés au médecin). Sachant que la chirurgie moderne a évolué à la technique aseptique, elle s'assurera avant tout de la propreté absolue de la plaie.

Pour répondre adéquatement le département médical d'une industrie doit comprendre une liste d'articles: meubles, instruments de chirurgie, pièces à pansements, etc. Il serait superflu de détailler d'avantage. Chacune sait ce qui est nécessaire et ce qui facilite son travail.

Le problème qui se pose ici c'est que certains dirigeants industriels n'ont pas la même conception de ce principe, voulant que le département médical influe directement sur la production. Ils attirent leur attention sur la fabrique immédiate de leurs produits, ne considérant le service médical que comme un palliatif. Ainsi, ils ne voient pas toujours la nécessité d'avoir tel ou tel article à cause des dépenses qui s'ensuivent. Dans de telles conditions l'infirmière est forcée de restreindre ses exigences. Elle doit se contenter de peu et essayer, avec ce peu, de produire beaucoup.

### Responsabilités

Parmi les principales responsabilités de cette infirmière industrielle, notons:

1. Dans certains cas, s'il n'y a pas d'examen médical à l'embauchage, elle devra établir un questionnaire, refuser les cas douteux ou les référer au médecin.

2. Traiter les blessures même les plus minimes, ainsi que celles qui surviennent à domicile afin d'éviter les infections.

3. Voir aux indispositions légères: maux de tête, indigestion, fatigue.

4. Référer au médecin les accidents sérieusement ainsi que les personnes souffrant de divers troubles de santé.

5. Tenir les fiches de ces malades et au besoin permettre, avec la collaboration du gérant du personnel et du contremaître, la permutation d'un travail plus approprié à l'état de santé.

6. Rapporter les cas d'accidents à perte de temps (de l'usine): (a) à la commission des Accidents du Travail; (b) s'il s'agit d'accident pouvant provoquer la mort, la perte d'un membre ou quelque gravité semblable, un rapport doit aussi être fait au Ministère du Travail, en vertu de la "Loi des Etablissements Industriels."

7. En cas de perte de temps de plus d'une semaine, soit pour cause d'accidents à domicile, soit pour maladie, un rapport doit aussi être fait à la compagnie d'assurance groupe afin que l'ouvrier reçoive compensation. Aujourd'hui, presque toutes les industries possèdent une telle police d'assurance.

8. De même en est-il pour les cas d'hospitalisation pour l'ouvrier et les membres de sa famille. Un rapport doit être fait en conséquence.

9. Contrôler les absences par des permis donnés aux employés et des enquêtes à domicile dans certains cas.

10. L'infirmière doit veiller sur l'hygiène et instruire individuellement.

11. Voir au fonctionnement du Comité de Sécurité et au bien-être des ouvriers.

12. Surveiller les maladies contagieuses et collaborer avec les médecins et infirmières du service de santé dès les premiers symptômes douteux.

13. Entraîner quelques ouvriers aux soins d'urgence est également utile.

14. Préparer les principaux désinfectants et les pièces à pansements.

15. Tenir des statistiques sur les activités de départment médical et présenter aux autorités de la compagnie un rapport de fin d'année. Dans les grandes industries où il est facile d'avoir des employés de bureau, des statistiques plus complètes peuvent être établies mais quand l'infirmière travaille seule elle ne peut donner tout son temps à la préparation cléricale mais elle doit tenir: une fiche individuelle; avoir des formules spéciales pour les cas d'hospitalisation, les maladies prolongées et les accidents du travail. Chaque usine diffère un peu sur ce point mais toutes doivent posséder un système de fiches, pouvant suivre l'état de santé des ouvriers et établir des statistiques convenables. Il est bien entendu que les fiches personnelles doivent demeurer confidentielles.

Chacun de ces items présente des difficultés d'application qui mériteraient d'être étudiées. Il serait trop long de les énumérer ici puisque j'entends développer des problèmes généraux. Signalons toutefois quelques points capitaux:

1. Quand l'infirmière est avisée de juger si un employé est apte au travail ou doit être refusé elle doit se garder de poser un diagnostic; si un tel geste venait au su d'un médecin, l'infirmière en serait blâmée. Je suis d'opinion qu'en ce cas l'infirmière doit agir sous forme de "suggestions."

2. Dans le traitement des plaies, l'infirmière se heurtera à plus d'un problème si elle prend trop de risques. Les infections sont le plus souvent dues à la négligence des ouvriers à leur domicile, cependant il est toujours plus facile d'en accuser l'imprudence de l'infirmière.

3. De même en est-il pour l'administration de médicaments.

5. De nombreux obstacles s'interposent dans la pratique d'accommoder un ouvrier temporairement handicapé, affaibli, en le changeant d'ouvrage. Cette permutation diminue souvent la production par le manque d'aptitude qu'à cet ouvrier à faire un nouveau travail, ce qui porte certains contremaîtres à désapprouver cet usage et expose l'infirmière à un nouveau problème.

9. Contrôler les absences est quasi impossible quand il n'y a qu'une infirmière mais il importe d'imposer certaines restrictions dans la distribution des permis d'absence.

10. Dans la mise en pratique des règles d'hygiène, l'infirmière ne reçoit pas toujours l'appui suffisant de certains chefs indifférents ou négligents eux-mêmes, trouvant tout naturel de cracher par terre, de fermer les fenêtres dans le but de ménager le combustible. Il arrive aussi que même avec la bonne volonté des administrateurs l'on se trouve en face d'un problème, lorsque l'application d'un règlement hygiénique affecte la production. Un tel aveu paraît ambigu mais non pour l'infirmière industrielle. Fouillons dans notre esprit et nous trouverons certainement des exemples à l'appui. (Ainsi dans notre usine, il y a un département où la laine doit être gardée à un degré très élevé d'humidité et une seule ouverture altère cette condition.) Imaginons le situation de ces ouvriers qui doivent y demeurer plusieurs heures par jour. Le seul adoucissement que nous ayions pu apporter à cet état de chose fut d'alterner le travail de deux équipes. Et combien d'exemples semblables ne pourrions nous pas fournir.

15. Dans la préparation des dossiers, le problème de l'infirmière est le peu de temps qui lui est alloué, car elle ne doit pas négliger l'ensemble de son travail. Trop de détails en ce sens provoquerait une lacune ailleurs, quoique l'infirmière trouverait souvent plus de satisfaction, dotée d'un meilleur système de fiches.

### Direction Médicale

Je ne sais si dans une grande cité comme celle de Montréal il est facile de collaborer avec les médecins d'une façon efficace mais dans notre ville de 20,000 de population ce moyen s'est avéré possible, grâce aux appels téléphoniques, aux visites faites aux bureaux des médecins, en invitant les médecins à venir à l'usine pour obtenir des renseignements concernant leurs patients et par l'échange de formules en cas de maladie ou d'accident. Il m'arrive souvent, en effet de rendre visite au bureau d'un médecin pour discuter d'un cas de l'usine.

L'absence du médecin à l'usine crée une lacune mais la méthode employée par l'infirmière peut compenser dans la mesure de son jugement. Si les directeurs d'usines ne sont pas obligés par la loi de s'associer un médecin, l'infirmière en conscience doit être sous sa dépendance et c'est à elle de s'assurer de sa collaboration par les moyens qu'elle juge efficaces. Cette collaboration constante échangées avec les médecins est une manière détournée si je puis ainsi m'exprimer d'avoir à l'usine la présence médicale.

### Collaboration

La collaboration avec les agences extérieures de santé est importante. Parmi ces agences notons: l'unité sanitaire, le service social, les compagnies d'assurance, les hôpitaux.

Même en dehors des grands centres l'infirmière a toutes les chances de coopérer non seulement avec les agences locales car les distances de nos jours comptent plus. Il arrive fréquemment que des malades se fassent traiter ailleurs que dans leur ville ou village. S'ils ne se déplacent pas les moyens de rétablissement se croisent. Les méthodes nouvelles multiplient les intermédiaires.

Tout en collaborant avec ces agences, l'infirmière découvrira certains problèmes. *Exemple:* Un ouvrier se présente un jour avec deux recommandations signées de personnes responsables: (a) l'une recommandait la reprise immédiate du travail; (b) l'autre l'interdisait complètement. Avec quelle délicatesse, quelle précaution, l'infirmière doit-elle agir devant un tel incident!

Le programme de santé dans l'industrie doit être profitable à chaque ouvrier:

(a) L'examen médical à l'embauchage est bien à recommander mais il n'existe pas partout. C'est alors que l'infirmière doit redoubler d'attention pour référer au médecin tout employé souffrant de malaise quelconque.

(b) Les conditions hygiéniques d'une usine doivent suivre les standards établis. Un ingénieur contrôle les poussières, les vapeurs, les fumées, les gazs, l'air, etc. Il faut qu'il y ait suffisamment

*(Suite à la page 929)*

*Public Health Nursing*

# The Nursing Assistant: Her Preparation

BETTY DAVIDSON

In considering the training program for nursing assistants, one naturally begins with the reason for the inception of such a program. The main purpose was to relieve and to share the services required of the nursing profession as a whole. As time goes on, the duties of the registered nurse are becoming more and more skilled and specialized. Progress over the years has raised the level of nursing from that of simply the bedside nurse to, in numerous instances, a highly technical skill that through those years has earned her a place among the professions. We now have psychiatric nurses, orthopedic nurses, industrial nurses, and so on. Indeed, in advancing to this position, it has meant that the energy, ability, and resistance of the individual registered professional nurse have been taxed to the utmost. In other words, she now needs an assistant.

As long as can be remembered, there has been the cousin, mother or neighbor lady who has turned up miraculously in time of illness in the home. She has the "knack" of caring for the sick and seemed to know just how to take hold of a situation. She was, and still is, invaluable. Keeping step with progress, the public, medical and nursing professions have brought this person into hospital where she again is most helpful in putting her hand to the routine tasks. Soon her many contributions settled her into a corner of the nursing service. Like Topsy, she "just grow'd." While in many instances her help has been invaluable, still there have been just as many times when accidents or misunderstandings occurred because she lacked the proper instruction and background for her role. Due to pressure of hospital routine, her introduction would consist of sporadic, on-the-job directions. There came a time when it was necessary for all concerned to face facts, and accept the reality that this worker was here to stay. Like any newborn infant, it had to be nurtured.

In 1941, it was felt in Ontario that some formal training program should be supplied for this worker to ensure thorough instruction and supervision and to equip her to work efficiently, under controlled conditions. A basic curriculum for such a training was set up by the Registered Nurses' Association of Ontario and used in collaboration with the nursing registries of Toronto, Hamilton, and London, thus establishing demonstration schools that were to become the embryo of what is today known as the nursing assistant course. A total of 107 trained people had been graduated by 1943 when the demonstration was considered successful and thereupon terminated. The curriculum that had been established was then forwarded to all hospitals of Ontario as a guide to be used in the training of their own auxiliary nursing personnel.

Three years later, in February, 1946, a course for practical nurses was established under the auspices of the Canadian Vocational Training program. It was based on the curriculum developed by the R.N.A.O. These classes were continued until September, 1946. A total of 18 young women were graduated under this form of organization.

In July, 1946, the Hon. Russell T. Kelley, Minister of Health for Ontario, conducted a survey in public hospitals to determine the shortage of trained personnel for the care of the sick. With the approval of the R.N.A.O. and the

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Ontario Hospital Association, it was decided that provincial funds should be made available for the establishment and conduct of a nine-month training course for nursing assistants, to be under the joint direction of the Departments of Health and Education. The first classes began September, 1946. Provincially sponsored training centres are located in Toronto, Fort William, and Kingston. From 1946 to 1948 a centre was operated in Hamilton.

In 1947, the Nurses' Act was amended to establish the title of Certified Nursing Assistant. Regulations set up under the Act provide that on successful completion of a provincial examination, the graduate becomes eligible for certification in Ontario. On payment of a $3.00 fee, the provincial registration certificate is issued. The regulations state that, without annual renewal of that certificate, there will be loss of title. The regulations provided for registration by waiver of examination for all who had gradnated prior to 1946, from the courses given by the Registered Nurses' Association of Ontario and Canadian Vocational Training.

Provision was made in the Nurses' Act also for the establishment, conduct, and maintenance of training centres by other institutions. Accordingly, an approved centre was set up in Prince Edward County Hospital, Picton, in 1946. The year 1951 saw the opening of another training centre in St. Vincent de Paul Hospital, Brockville. A third approved school has been established in Sunnybrook Hospital, Toronto, under the sponsorship of D.V.A.

The regulations state that the age of the applicant must be a minimum of 18 years and she must present evidence of Grade VIII education or its equivalent. In addition, certain letters of reference are requested, as well as a report of a medical and dental examination. If at all possible, each applicant is interviewed personally prior to acceptance. Applicants come to us with a variance of experience and interests. There may be the girl in her early thirties who has had family responsibilities that prevented her from completing high school and entering a school of nursing. Many young girls, of course, come directly from school. Then, too, there is the older woman who has raised a family and now finds that she has time to take a training for which she has always longed.

Regardless of background, fundamentally they all like people and wish to be able to enjoy the satisfaction of being helpful. This is a common bond that tends to bind the classes together. It is of interest to note, on many occasions, the spirit of competition that arises between the various groups within a class. Usually the older trainee has definitely made up her mind what she has come for but needs guidance in developing her skills. On occasion, the younger trainee must be shown the degree of responsibility expected of her and be assisted in her acceptance of the personal demands made by nursing upon the individual.

The staff of all centres now in operation are well qualified registered nurses, alert to the needs of this worker, ready and able to provide understanding guidance, either academic or personal. The teaching methods that must be employed in presenting material to classes of such varied background, interests, and age ranges, offer no small challenge to the adaptability and ingenuity of the instructor. Considerable repetition of details, presented clearly and concisely, is at all times necessary.

In the preparation of the nursing assistant, it is kept in mind that she will need to be ready to take her place in home nursing as well as in institutional fields. The entire outline of the course is geared to give sound insight into the responsibilities the nursing assistant must shoulder in accepting her share of patient care. On completion of the course, she is prepared to assist the registered nurse in giving good bedside care to convalescent, chronically ill, and non-acutely ill patients. It is to be hoped that at all times she will be working along side of and with the guidance of the registered nurse. During the nine months of training, a great deal of stress is placed upon the importance of harmonious inter-personal relationships—be they with patients or fellow classmates. The proper approach to difficult situations, the need to seek guidance if uncertainty exists—in short, the ability to recognize

her limitations—is stressed with the trainee from her first months in the school.

A distinctive uniform has been designed for the nursing assistant, consisting of a plain, apple-green short-sleeved dress, over which is worn a white, double-breasted, hoover-type apron. With this are worn brown oxfords and street hose. In the sixth month of training, the trainee receives the white cap edged with a narrow green binding. Upon graduation, the certified nursing assistant pin is added to complete the uniform. Once the graduate's certification number is established, her pin is forwarded.

The certified nursing assistant uniform is designed to be easily distinguished from that of other members of hospital staffs, both professional and non-professional. It is to be hoped that the trainee will continue, as a protection to herself and to her patients, to wear this uniform after her training is completed. Throughout the nine months an effort is made to foster in the trainee a pride in the distinctive uniform. Directors of nursing have been asked to assist the Department in establishing this uniform by requesting that all the certified nursing assistants on their staffs wear only the uniform described above. We might say that quite generally it is the practice to do so.

The more contact one has with this worker, in whatever field, the more one becomes aware of her need for professional guidance. While a considerable share of responsibility for the protection of the patient rests on the shoulders of the certified nursing assistant herself, a still greater responsibility rests with the registered nurse with whom she is closely working. The assistant is a new personality in the nursing field. Only now, after approximately six years of concentrated training, is she beginning to be noticed, admired, and respected as having a very definite status in the field of nursing.

Speaking broadly, the nursing assistant's duties consist of simple treatments and general bedside nursing. She is taught neither aseptic technique, nor hypodermic administrations, but rather relieves the registered nurse that she may perform these more specialized tasks. The nursing assistant gives bed-baths, enemas, gets the patient up, tends to the cleaning of a unit, feeds patients and many other tasks, all of which add up to good nursing care. After a basic three-month period in the central school, where concentrated classroom work and practice with demonstration equipment is given, six months are spent in supervised experience in hospitals. During the whole period many observation trips are provided to community facilities in the area. By the end of her training, she will have shared in the care of children, aged men and women, convalescent, medical and surgical patients, and patients in hospitals for the mentally ill or tuberculosis sanatoria. Indeed, her training has been a well-rounded one.

Today in Ontario, the entire group known as nursing assistants is like any youngster venturing forth to attain its independence. It is going to make mistakes, be criticized, act bad tempered but, in spite of all this, become a valuable member of the community. For this reason, she needs to find understanding and tolerence among her neighbours and, above all, encouragement. We know that she is becoming a very important member of the nursing group but she needs to feel that importance and acceptance. Inherently the need for *belonging* is essential to the happiness and well-being of all of us. The role of the accepting good neighbor is one that must be filled primarily by us of the nursing profession. We can then, in turn, solicit the support of the medical profession and the public.

Considering the program purely from a supply and demand standpoint, it would seem that the time when the saturation point in the number of certified nursing assistants is reached is quite some distance in the future. To date, there are 1,089 graduates and though a few of these are not active in nursing, the numbers still fall short of meeting the requests for their services. If the success of the training were based solely on the inquiries received, there would be no hesitation in saying that the future of the nursing assistant training programs does, indeed, look bright.

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Who learns with method retains with certainty.—H. TAINE.



# *Trends in Nursing*

## I.C.N. Congress in 1953

Arrangements for the I.C.N. seem to be in full swing now. Mrs. Clerk, the C.N.A. Convention Chairman, has been conferring with various transportation officials about fares and tours with an eye to helping all Canadian members get the most out of their trip. After all, one does not take a trip to "Rio" every year! All the interested should be sending in their names to National Office so that as soon as there is definite information available it can be sent out to them.

## Psychiatric Nursing

There is a growing interest being shown in psychiatric nursing course curricula. At its last general meeting the C.N.A. endorsed a resolution expressing a need for a more uniform and specific curriculum in non-professional psychiatric nursing. A committee is being set up for this purpose. The Mental Health Division of the Department of National Health and Welfare has also been inquiring into non-professional courses and the Canadian Mental Health Association is showing interest in what the student nurse learns about mental hygiene. The C.N.A. National Office is cooperating in every way possible with the three groups. We hope that from these various activities will come some concrete suggestions for the strengthening of psychiatric nursing in Canada.

## Intergroup Relations

Discussing the reports from experts called in from industry and universities to study interpersonal and intergroup relations in the hospital, the conclusion was that two main circumstances seem to account for the hospital being an organization that is most complicated and difficult in this respect. The first was that a hospital employs the people who work there but the doctors tell them what to do. Second, the hospital is made up of the most rigid caste system in which individuals cannot rise above the level of their own particular group.

In a democratic society, which prides itself on the fluidity of its social classes, the hospital permits an average employee less hope of improved social standing than he has been taught to expect of life generally. Unlike employees of industry who learn their skills on the jobs and can often more along as rapidly and as far as their abilities will take them, hospital employees are frequently frozen in layers; the employee who advances to the top of his own layer has gone about as far as he can go; the hospital population consists for the most part of nurses who can never be doctors, aides who can never be nurses, maids who can never be aides, and little groups of technicians who are remote from everybody, including one another.

The writer goes on to say that this development of compartments, particularly by professional people, has been obvious over the years. The administrator, though, has still to contend with it and to attempt to find a solution. The answer does not seem to be "in group meetings in which everybody is under embarassed compulsion to use first names" but in the development of a broad philosophical view.—*The Modern Hospital*, Aug. 1952.

## The Harper Hospital Study

We have been hearing a great deal about the Harper Study which was carried on from July 1, 1950, to January 1, 1952, in Detroit, Michigan. Its purpose was to provide adequate and safe patient care economically and to give job satisfaction to the personnel.

As professional nurses, we are most interested in the work that was done to determine the functions of the professional nurse and what duties may be safely left in the hands of the non-professional worker in the hospital. Questionnaires were planned for doctors, patients, nurses, and non-professional staff. When the results were tabulated many interesting facts were forthcoming. In general it was found that both patients and doctors were willing to have non-professional workers giving patient

care but they were uncertain as to just what these workers could do. After compiling a master function list, the group of experts classified the functions according to departments and workers who should do them. Then they checked carefully on times of peak loads where different categories of workers were needed and were able to emerge with clear-cut staffing patterns. A sample pattern quoted from a surgical service is: 20 per cent professional nurses; 20 per cent practical nurses; 45 per cent aides; and 15 per cent clerical workers. This and similar patterns have proven workable. At the same time, work simplification techniques were devised and a program of instruction instituted. In general, major changes made which affected nursing services were: *central messenger service; transfer of housekeeping duties.*

The latter involves more housekeeping staff and an extension of their duties to include terminal cleaning of units, care of all routine patient-care equipment, care of flowers, cleaning of bedside lockers in both unoccupied and occupied units, cleaning of cupboards except the narcotic cupboard, and other similar duties.

*Dietary and food service:* In general the nursing personnel is responsible for preparing and helping with patients' trays but the dietary personnel deliver and collect trays, and drinking glasses and jugs.

*Exchange linen carts:* These are kept up to standard by the linen room personnel and are arranged conveniently for use in patient care.

Improved *central supply room* service: A standard amount of equipment is kept on the unit and is returned on an exchange basis.

## The Rockefeller Foundation

During 1951 appropriations for public health and medical services totalled $3,796,270. The program in this division is being developed along four fronts: the advancement of professional education; the study of medical care; the investigation and control of specific diseases and deficiencies; and the development of the health sciences. As a general principle, the Foundation is stressing a closer coordination of all its activities through the development of related programs along the broad front of health, agriculture, education, social sciences, and humanistic studies. This is of interest to those who have been studying the activities of WHO. Dr. Brock Chisholm, director general of WHO, emphasized in an article in the *WHO Newsletter* that:

> During the past years, it has been made clear that modern methods of combating disease and promoting health are useful only if their application is satisfactorily adjusted to widely differing stages of social, cultural, educational, and institutional development.

## Revisions—in Progress and Projected

There have been many requests recently for copies of "What You Want to Know About Nursing" which National Office has been unable to fill. Although the last edition came out as recently as 1950 there have been such numerous changes in entrance requirments to schools of nursing, personnel policies, the general attitude towards the life of the student nurse, and in career opportunities for registered nurses that it has become necessary to make still further revisions. In collaboration with the Department of National Health and Welfare, and acting upon suggestions from the provincial associations, this new edition is being prepared. It is not possible to predict when it will be ready for distribution but both the Department of National Health and Welfare and the C.N.A. are eager to have it available upon request as soon as possible.

The *Canadian Nurse* article "Opportunities for Post-Graduate Study" was reprinted from the April 1951, issue. As it has not completely answered the many requests for information received in National Office a new folder is to be prepared in the near future. It is planned that data concerning post-graduate courses will be more detailed and broader in scope.

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If anything external vexes you, take notice that it is not the thing which disturbs you, but your notion about it—which notion you may dismiss at once, if you please.

—MARCUS AURELIUS.



# Orientation et Tendances en Nursing

### LE CONSEIL INTERNATIONAL DES INFIRMIÈRES

Les préparatifs concernant le Congrès du C.I.I. vont de l'avant. La convocatrice des congrès de l'Association des Infirmières Canadiennes, Mme Clerk, a visité plusieurs agences de voyage dans le but de renseigner nos membres sur le prix de passage, les excursions, etc. Après tout, l'on ne va pas à Rio tous les jours! Toutes les intéressées devraient envoyer leur nom aussitôt que possible au Secrétariat National, a fin que, dès que la chose sera possible, nous leur fassions parvenir des informations.

### LE NURSING EN PSYCHIATRIE

Un intérêt marqué se dessine concernant les cours de psychiatrie. L'A.I.C., lors de sa dernière assemblée générale, a appuyé une résolution exprimant la nécessité d'un programme spécifique, plus uniforme pour les aides-malades en psychiatrie. Un comité a été formé pour étudier cette question. La Division de la Santé Mentale du Ministère de la Santé et du Bien-Etre Social étudie cette question de cours donnés aux aides. De même la "Canadian Mental Health Association" s'intéresse au programme d'hygiène mentale donné aux étudiantes infirmières. Le Secrétariat National coopère de tous ses moyens avec ces trois groupes. Nous espérons que de toutes ces études naîtront des suggestions pratiques.

### RELATION INTERDEPARTEMENTALE

Des experts en relation, venant de l'industrie et des universités, présentent le rapport d'une étude sur les relations du personnel et les relations interdépartementales de l'hôpital. L'hôpital présente des difficultés que l'on ne rencontre nulle part.

En premier lieu, l'hôpital emploie les personnes qui y travaillent mais les médecins sont ceux qui leur disent ce qu'elles doivent faire. En second lieu, l'hôpital se compose de classes absolument fermées les unes aux autres—un membre d'une classe ne peut s'élever à une classe supérieure.

"Dans une société démocratique, l'on se glorifie de la facilité de transformation des classes sociales, mais à l'hôpital un employé n'a aucune chance d'améliorer sa position sociale. Contrairement aux employés d'industrie, qui apprenent leur métier en travaillant et qui peuvent bien souvent avancer aussi loin où leur talents les conduiront, les employés d'hôpital sont souvent fixés dans leurs castes. L'employé qui est devenu chef de son propre groupe ne peut espérer d'aller plus loin. Le personnel de l'hôpital se compose en grande partie d'infirmières qui ne seront jamais médecins; d'aides qui ne seront jamais infirmières; de bonnes qui ne seront jamais des aides; et d'un petit groupe de techniciens vivant à part des autres et souvent étranger l'un à l'autre."

L'administrateur doit se contenter de cet état de chose et essayer de trouver une solution. Faire des réunions de toutes les catégories du personnel où chacun est embarrassé d'appeler l'autre par son prénom ne semble pas la solution. Cherchons plutôt à developper des idées larges, inspirées par une saine philosophie.—*The Modern Hospital*, août 1952.

### "THE HARPER HOSPITAL STUDY"

Nous avons bien entendu parler de cette étude qui a eu lieu à Détroit, Michigan, du 1er juillet 1950 au 1er janvier 1952. L'étude avait pour but de déterminer les moyens à prendre pour assurer économiquement des soins adéquats aux malades et assurer au personnel une satisfaction au travail.

Comme infirmière professionnelle, nous sommes très intéressées de connaître ce qui a été fait dans le bùt de déterminer les attributions de l'infirmière et également de connaître les attributions confiées au personnel auxiliaire à l'hôpital. Des questionnaires furent envoyés aux médecins, malades, infirmières, et au personnel auxiliaire. Une fois la compilation des réponses terminée, des faits intéressants se révélèrent. Les malades et les médecins acceptent volontiers les soins donnés par les auxiliaires mais demeurent indécis au sujet des attributions exactes de ces aides.

Après avoir dressé une liste type des fonctions du personnel de l'hôpital, les experts les ont classifiées d'après les différents départements et les diverses catégories d'employés devant remplir ces fonctions. Aux heures où le travail est le plus intense, ils ont étudié quelle catégorie de personnel

était le plus nécessaire et ils ont été capables d'établir les cadres d'un personnel bien équilibré.

Par exemple, l'on a dans un service de chirurgie: 20 pour cent d'infirmières professionnelles; 20 pour cent de "practical nurses"; 45 pour cent d'aides; et 15 pour cent de commis de bureau. Cette équipe et d'autres du même genre se sont avérées très satisfaisantes. Des méthodes simplifiées de techniques furent établies en même temps qu'un programme d'instruction. Les changements les plus importants affectant le service du nursing sont: *un service central de messagers; tous les soins du ménage confiés au service de l'entretien.* L'exécution de ce dernier plan demande un plus grand nombre de domestiques lesquels devront faire le ménage de la chambre du malade à son départ, nettoyer tout ce qui lui sert ordinairement, le soin des fleurs, nettoyer la table de nuit, les armoires sauf le cabinet des narcotiques, etc.

*Diététique et service des repas*—En général les infirmières ont la responsabilité de préparer et de servir les plateaux des malades. Le personnel de la cuisine de diète ramassera les plateaux, les verres et les carafes.

*Chariot de lingerie*—La lingerie nécessaire aux malades est déterminé et le personnel de la lingerie a la responsabilité des chariots.

*Service central*—Une quantité déterminée de matériel est gardée dans le service. Ces articles, après usage, sont échangeables au service central.

### La Fondation Rockefeller

Durant l'année 1951, la somme de $3,796,270 a été dépensée pour des services médicaux et de santé. Dans cette division le programme est sous quatre chefs: l'avancement de la formation professionnelle; l'étude des soins aux malades; la recherche et la restriction des malades spécifiques; le développement des sciences en regard de la santé. La Fondation a pour principe général, lorsqu'il s'agit d'une question de santé, d'appuyer sur la coordination de programmes dans les divers domaines s'y rattachant tel que: l'agriculture, l'éducation, les sciences sociales, et les humanités.

Celles qui ont étudié le travail accompli par l'O.M.S. y reconnaîtront le même principe dans cette déclaration du directeur:

"Depuis quelques années il a été prouvé que les méthodes modernes de combattre la maladie et de promouvoir la santé sont utiles en autant que leur application s'adapte à toutes les classes de la société, aux différentes cultures, et au développement des institutions scolaires et hospitalières."

### Clarté sur la Profession d'Infirmière

La brochure anglaise "What You Want to Know About Nursing" est épuisée et dernièrement l'on n'a pas été en mesure de répondre aux demandes. Bien que la dernière édition ne date que de 1950, il y a déjà de si nombreux changements sur les conditions requises à l'admission dans le écoles d'infirmières, dans la ligne de conduite et dans l'attitude en général envers l'étudiante infirmière, et dans les carrières offertes aux infirmières, qu'il semble nécessaire d'en faire une révision. En collaboration avec le Ministère Fédéral de la Santé et du Bien-Etre Social, l'Association des Infirmières Canadiennes est à préparé la nouvelle édition de ce bulletin. L'on a tenu compte des suggestions des associations provinciales.

Il est impossible de déterminer la date de la publication de la brochure mais l'on fait diligence de part et d'autre pour que ce soit le plus tôt possible.

### Facilités d'Accès aux Etudes Supérieures

Afin de répondre à de nombreuses demandes un tirage à part a été fait d'un article paru dans *The Canadian Nurse* d'avril 1951—"Opportunities for Post-Graduate Study." Néanmoins cet article ne donne pas tous les informations dont dispose le Secrétariat National et des données plus complètes sur le sujet seront préparées.

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L'infirmière en psychiatrie de l'avenir devrait être une personne de grande intelligence, possédant une très vaste instruction. Ses connaissances des données de la psychiatrie devraient être considérables: en un mot, elle sera un complément du psychiatre. Elle se devra d'être spécialiste dans l'art de solutionner les problèmes de l'être mentalement épuisé; apte et prompte à saisir le sens de la moindre déviation de sa conduite; capable d'interpréter les actions et gestes des patients et capable aussi d'apprécier la signification de certains symptômes.



*Student Nurses*

# Nursing Care of Suprapubic Prostatectomy

Betty Rudd

A surgeon once stated that "to cut well and sew well" meant to get well. With only slight meditation the inaccuracy of this statement can soon be visualized. Good surgical technique is definitely essential and advantageous but the speed of convalesence and results of an operation are directly dependent upon much more than the actual "cutting and sewing." This important factor is good pre- and post-operative care. Standing beside the patient and the physician is the nurse who, because of her strategic position, plays a very vital part in the ultimate outcome.

What is expected of the nurse? In order to present adequately the nursing care of any patient, it is essential for the nurse to realize, first, the understanding of him as an individual; second, the type of operation and body organs involved; third, the necessity of adjusting didactic teaching to meet the situation. Now let us focus our attention on one particular type of surgical patient —the patient who is to undergo a suprapubic prostatectomy.

The prostate gland is situated immediately below the internal orifice of the urethra, the posterior urethra being surrounded by it. The gland is about the size of a chestnut and consists of a dense, fibrous capsule containing glandular and muscular tissue. The glandular portion is composed of tubules which communicate with the urethra by minute orifices. The gland's function is to secrete the prostatic fluid. The urine, on leaving the bladder during urination, must pass through the middle of the prostate gland. When the gland tissue contained in the prostate becomes hypertrophied, as it does in many men by the aging process, it causes obstruction to the outflow of urine, with its attendent signs and symptoms namely, retention with overflow, dysuria, hematuria, nocturia, dribbling. In many cases the condition can only be alleviated by an operation. Thus a suprapubic prostatectomy means removal of the hypertrophied tissue from the middle of the prostate gland, by an abdominal incision in the area above the symphysis pubis.

A typical prostatic patient is a man of about 60 years of age in only fair physical condition, fairly well set to his pattern of living, somewhat uncooperative and pessimistic, with slight cardiorenal involvement, hemoglobin below safe surgery level, appetite poor accompanied by a degree of dehydration. Perhaps this picture will provide a better understanding of what nursing measures are essential, precautions to be taken, complications that are likely to occur post-operatively, and thus will show the prophylactic measures that should be initiated pre-operatively.

### Pre-operative Management

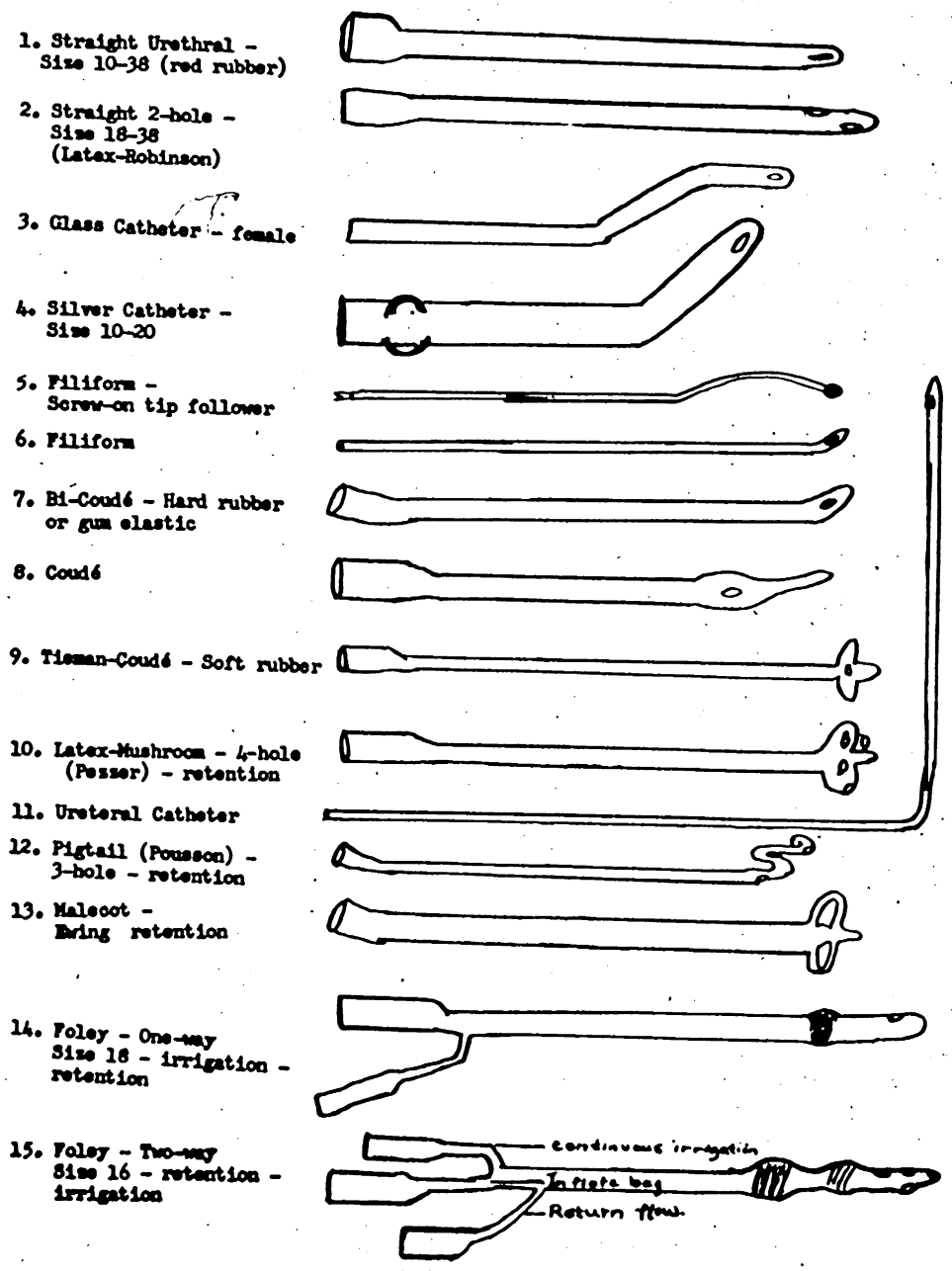
The objective of pre-operative care is to prepare the patient so that he will be in the best possible condition for surgery. The means of achieving this goal are determined largely by the needs of the individual patient, the degree of senescence, his physical condition upon admission, the severity of the case, in fact any factor which will determine in any way the amount of surgical risk involved.

*Mental preparation:* The psychological aspects of nursing these patients should never be overlooked. Sympathetic understanding, a word of explanation offered willingly, an optimistic, cheerful manner,

Miss Rudd was a senior student at the Hamilton General Hospital, Ont., when she prepared this material.

personal interest, patience and confidence, will add greatly in gaining the patient's cooperation and, in turn, in decreasing the period of convalescence. The nurse should make every attempt to make these patients feel important. She may do this to a degree by teaching the patient to help himself—for example, to keep track of his fluid intake. The nurse must teach her patient the need for carrying out the doctor's orders; the importance of adequate fluid intake; the prevention of obstruction to any urinary drainage; the need to report any new physical developments. Once the patient's confidence and cooperation are gained the nurse will find physical preparation easier and results more gratifying.

*Physical preparation:* Adequate drainage is usually obtained by an in-dwelling Foley catheter attached to a Y-tube irrigator. A suprapubic cystotomy is used


1. Straight Urethral - Size 10-38 (red rubber)
2. Straight 2-hole - Size 18-38 (Latex-Robinson)
3. Glass Catheter - female
4. Silver Catheter - Size 10-20
5. Filiform - Screw-on tip follower
6. Filiform
7. Bi-Coudé - Hard rubber or gum elastic
8. Coudé
9. Tieman-Coudé - Soft rubber
10. Latex-Mushroom - 4-hole (Pezzer) - retention
11. Ureteral Catheter
12. Pigtail (Pousson) - 3-hole - retention
13. Malecot - Ewing retention
14. Foley - One-way Size 16 - irrigation - retention
15. Foley - Two-way Size 16 - retention - irrigation
Continuous irrigation
Inflate bag
Return flow





in those cases where catherization is impossible or contraindicated—for example, acute urethritis—or as a first-stage procedure in a poor-risk patient. These measures will relieve the retention with overflow.

A common irrigating solution is Zephiran 1:20,000 used as an antiseptic to cleanse the tubing; to wash out the bladder and so to decrease the amount and to prevent the development of further urinary infection. Other solutions may be ordered such as Suby's G, boracic 2%, lactic acid 2%. The latter are used when the urine is alkaline (caused by urea-splitting organisms) in an attempt to render the urine acid and so prevent the formation of phosphatic material which tends to clog the drainage tubes.

Principles of maintaining urinary drainage which apply post-operatively also apply pre-operatively—namely, prevention of obstruction either physically, mechanically or chemically. These will be discussed later. The nurse should remember always that "no drainage tubing at all is better than a clogged tube."

*Prevention of dehydration:* The fluid intake and output must be adequate. Increased amounts of fluids promote better kidney function as a dilute solution is easier to secrete than a concentrated one. In addition, fluids will decrease the amount of infection by washing out the products of inflammation. Fluids, orally or intravenously as ordered, must be given in amounts of at least 3,500-5,000 cc. in 24 hours. One of the nurse's chief duties is to keep an accurate measurement of fluid intake and urinary output. These patients must drink all they can. Therefore the nurse must use her persuasive powers, her ingenuity, and her creative ability in making fluid drinks as palatable and as varied as possible.

*Diet:* The dietary regime must be adequate, nutritional, high in proteins and vitamins in order to rebuild body tissues and to improve the general physical condition. Malnutrition is a definite factor predisposing to a greater surgical risk and to poor healing later. Since most of these patients are elderly their eating habits are fairly fixed. Again the nurse should cater to her patient's preferences; give mid-morning, afternoon and evening snacks of eggnogs, milk-shakes or some other protein drinks. Meals should be served attractively to encourage the patients to eat.

*Laboratory tests:* Routine procedures are carried out upon admission. These include: microurinalysis and culture to determine the presence of infection. A low fixed specific gravity indicates kidney damage, thus patients showing this problem must put out much more urine than the normal patient in order to excrete the nitrogenous wastes. This accounts for the volume of urine which is passed at night equaling or exceeding that passed during the day.

Blood tests include chemistry to measure the non-protein wastes accumulating in the blood stream. A high reading indicates poor kidney function. Acid phosphatase if over 10 K.A. units is fairly definite proof of carcinoma of the prostate or of secondaries. Sedimentation rate is sometimes done to determine the degree of infection, the normal being five minutes per millimeter. (Kidney, ureters, bladder x-ray plates may be taken if presence of calculi is suspected).

*Physical examination:* A complete examination is usually made by the physician prior to hospitalization. However, the intern may be asked to check certain details of the case. The physician may find a rectal examination of great value since the posterior surface of the prostate is in contact with the anterior wall of the rectum. When doing a rectal examination the physician can easily determine whether or not the gland is enlarged. The encircling of the gland often gives the physician some information—whether the enlargement is benign or malignant.

*Immediate pre-operative care:* The operative area is cleansed and shaved, as required by the doctor, the night before the operation. Sedation as ordered is given to ensure a good night's sleep. The nurse checks to see that the patient's blood has been crossed and typed. Some patients may require transfusions previous to operation for anemia and general body condition. All this time it is the nurse's duty to keep a close scrutiny of the patient for factors which may lead to complications following surgery.

The patient is ready for operation

when he is "sleeping, eating, drinking and feeling well, and blood chemistry has returned to normal or at least become stabilized."

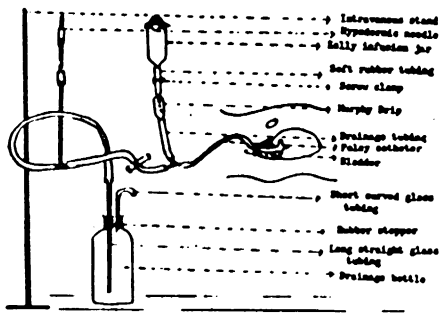
### Post-operative Management

Immediately following an operation the nurse is concerned with life-saving measures. The patient's life may depend upon her accurate noting, recording, and interpreting of vital signs and symptoms; the administration of drugs and intravenous fluids; and efficient working of any special equipment.

While the patient is in the operating room the nurse should prepare any equipment likely to be used upon the patient's return. Some sort of drainage is inevitable following a suprapubic prostatectomy, the usual being a through and through drip irrigation by which the irrigating fluid enters the bladder via the urethral catheter and escapes via the suprapubic tube. If only a suprapubic tube is used it should be connected to a Y-tube irrigator. In addition to this drainage equipment an intravenous stand should be at hand. The environmental conditions should be salubrious: an anesthetic bed warmed; no drafts; no excess material present.

Upon his return from the "O.R." the patient should be lifted carefully into bed in order not to dislodge the tubings. Take a good over-all look at the patient's condition, connect any drainage tubing, check incision. The nurse must be alert and observant!

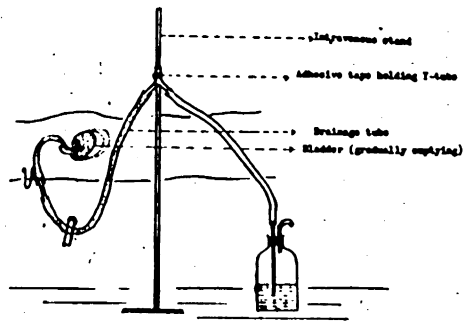
### Tidal Irrigation




Tidal irrigation is an automatic irrigation. It may be used on any bladder through a catheter or through a suprapubic button catheter. It is used particularly in patients with a paralyzed bladder resulting from spinal injury; in patients with a hypotonic bladder, whether myogenic or neurogenic; or in a badly infected bladder.

When using tidal irrigation the T-tube *must* be on level of the bladder. Thus, the fluid released from the Kelly infusion jar will run to both bladder and T-tube (both are on same level and connected through Y-tube). Only way the fluid can escape from system is by climbing loop of drainage tube. As fluid always seeks its lowest level, when the fluid is in this loop, it is always rising in the bladder or filling bladder. The loop of the draining tube being opaque, the fluid level cannot be seen here but can be watched on long arm of T-tube. As soon as level of fluid reaches level of loop, it falls into drainage bottle. This starts a siphon drainage of bladder, continues until bladder is empty as long as it is not allowed to enter through long arm of T-tube too fast. This is why a small hypo needle is inserted in long arm of T-tube—to allow air to enter slowly so that siphon will not be broken before bladder is empty. As soon as bladder is empty, and air breaks siphon, whole process of refilling bladder is started again. The amount of fluid allowed in bladder each filling is regulated by raising or lowering top of loop of drainage tube. The higher the top, the more fluid will enter bladder. The rate of filling bladder is regulated by rate of drip in Murphy Drip.

### Y-Tube Slow Compressor




This method is used only to empty bladder slowly; patients with chronic retention with overflow and especially those with high blood chemistry. Dangers of too sudden compression of an over-distended bladder: (1) hemorrage; (2) anuria; (3) uremia.

The Y-tube, after being connected to catheter with drainage tube, and air is expelled from tubing, is fastened to intravenous stand at height where level of urine is seen in proximal arm of Y-tube.

If patient is asked to take a deep breath,





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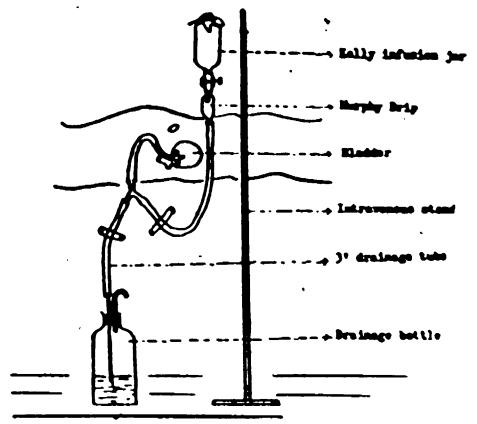
thereby increasing intra-abdominal pressure, or if pressure is made with hand in suprapubic region, the level of urine oscillates in Y-tube, and one is certain that there is no block between Y-tube and baldder.

As the urine is made to run uphill as it were, the only force that will make it do this is increased tone on bladder musculature. The height of the fundus of bladder is watched daily and the height of the Y-tube is gradually lowered, as bladder regains its musculature.

*Care of equipment*—As it takes only 2½-3 days to empty bladder, the equipment need not be taken down for cleaning, unless necessary due to clots or very dirty urine. When the bladder is empty, a Duke's irrigator is used.

### Duke's Irrigation

This system has a closed drainage bottle as shown, thus keeping down odors. The advantage of this method of irrigation is that being "closed" it prevents cross-infection from and to other patients. Therefore each time it is taken apart for cleaning the end must be protected by piece of gauze moistened with alcohol. When equipment is disconnected from catheter to allow patient out of bed, both




ends—the end of catheter and end of Y-tube —must be protected by alcohol moistened gauze pad.

*To irrigate bladder*—(1) Open screw-clamp on soft rubber tube above Murphy Drip. (2) See that fluid runs freely at Murphy Drip and at Y-tube. (3) Pinch with thumb and finger outlet tube from Y-tube to drainage bottle. (4) Fluid should still run free at Murphy Drip—if not, catheter is blocked. (5) Allow 2-6 oz. of fluid to enter bladder. (6) Then release pressure on outlet tube and simultaneously apply pressure with thumb and finger

to inlet tube below Murphy Drip. (7) This allows fluid to leave bladder and drain into drainage bottle. (8) Continue irrigation until fluid leaving bladder through Y-tube returns clear.

*Care of equipment*—(1) Remove Y-tube. (2) Remove drainage tube to bottle. (3) Remove drainage bottle cork and two glass rods. (Every other day remove these; clean with green soap and water; flush through with $H_2O$; boil 3 min.; replace.) While parts are away being cleaned protect end of catheter and inlet tube with alcohol moistened pad.

### Complications

*Hemorrhage and shock:* These are twins—one as treacherous as the other. Pulse, respirations, color, bleeding will indicate whether complications are imminent. Check the pulse and respirations every ten minutes until consciousness is gained. If hemorrhage is occurring the patient will be restless, apprehensive, with the pulse rapid. Excessive bleeding, if persistently red, will indicate hemorrhage from the prostate bed.

If shock is present the extremities will be cold, cyanotic; pulse weak and thready; respirations rapid and shallow. Apply warmth at once, notify the doctor, prepare equipment for transfusion of whole blood. If excessive bleeding occurs, tension to urethral catheter may be applied by an elastic band attached to the Foley catheter and this fastened to a bandage passed around the leg below the knee.

*Urinary obstruction:* A thorough understanding and skilful management of drainage tubing is paramount to the avoidance of urinary obstruction. Obstruction may be mechanical, physical, chemical. Mechanically, obstruction may be prevented by pinning the tubing in a straight line from the drainage bottle; by not allowing the patient to lie on the tubing or let the bed sides pinch off the tubing; by permitting ample tubing for the patient to move in bed. Physically, obstruction may be avoided by employing a firm tube with a large bore, large glass connectors, frequent changing of tubing —every two days and as required. Chemically, obstruction may be removed by frequent irrigations as required until there is no bleeding, then four times daily until the suprapubic drain is removed. Antiseptic solutions may be ordered to prevent blood clot and inorganic salt formation. Suction by a pump may be required in order to overcome obstruction. The nurse should keep in mind the aim of irrigations—to combat any existing infection which would delay healing and to prevent stasis of blood in the urinary system.

*Emboli formation:* This is an insidious, dreaded post-operative complication. The chief prophylactic measures are early movement in bed, adequate fluid intake, early ambulation. Get the patient to "breathe deeply, cough freely, and move the legs about." Prostatic patients have a tendency to remain in bed. Only quiet persuasion, patience and encouragement will gain their cooperation. Early ambulation has threefold advantages: prevention of emboli; improvement of body tissue tone; promotion of optimism in mental outlook of patient.

*Cardiac involvement:* Senescence is a contributing factor to both cardiac and pulmonary manifestations. An even greater burden is placed upon these organs at the time of anesthesia, coupled with any profuse loss of blood following surgery. Again early movement and vigilance for any signs and symptoms of these complications are necessary.

### General Nursing Care

Fluids in sufficient amount cannot be over-stressed. As 3,500-5,000 cc. in 24 hours is essential, it may be given orally, subcutaneously or intravenously, depending on how the doctor orders it. The usual method, for 48 hours post-operatively, is by intravenous with 5-10% glucose in distilled water or saline as ordered. This measure aids greatly in offsetting shock, dehydration, and general body debility. The diet is stepped up as regularly as possible in order to quickly regain bodily strength. Plenty of proteins and vitamins are essential and may be provided partially by mid-morning, afternoon and evening snacks as in the preoperative period. Again intake and output must be measured. Water is the best and safest fluid.

The position of these patients in bed is important. As soon as anesthesia allows (six hours in the case of spinals) place the patient in semi-Fowler's posi-

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tion to relieve strain on the incision. Turn him on the unaffected side to facilitate drainage. Always have assistance in turning these patients in bed to conserve your energy as well as your patient's and to prevent strain on the incision.

The dressing of the wound should not be neglected. For 24 hours post-operatively the dressing should only need to be checked. However, never allow a dressing to become saturated with drainage. Change as frequently as needed. Note the type and amount of drainage, the condition of the wound, and the presence of any foul odor which may indicate infection or urine decomposition inside the body. Sutures will be removed when the doctor feels they are no longer desirable, usually in seven or eight days.

Sedation, as ordered, should be given to alleviate pain. Prior to giving sedatives check to see that there is no other cause for the discomfort, such as obstruction to drainage. Any distress or complaint of discomfort should be investigated at once. Later on sedatives may be required only for sleeping.

A crucial period in the recovery of these patients takes place at the time when all catheters are removed. The nurse may expect a great deal of drainage from the abdominal incision for a while but proper urinary function should soon be restored. Thus a careful check on the voiding of these patients is essential.

### Rehabilitation

Any patient who has undergone surgery, especially a major operation, faces the matter of rehabilitation. The past war has proven how important this is in the life of an individual. As nurses it is our responsibility, to a degree at least, to discharge a patient from the hospital who is fairly well adjusted to face the future cheerfully and confidently.

The degree of success will depend naturally upon the type of patient involved, his age, his social and financial status. A prostatic patient is elderly—a factor adverse to rehabilitation as a rule. However, senescence need not present too grave a problem. In confidence talk over the situation, help him to understand his limitations, how to attend to any medications upon discharge and, above all, teach him basic everyday hygienic measures of living. The latter include: plenty of fluid intake, high protein diet, plenty of rest and sleep.

No matter what problem may arise the nurse must remember that the patient is an individual. Knowledge and practice of this fact will help smooth many a rough road encountered in nursing patients—prostatic or otherwise—back to a healthy state of body and mind.

# Book Reviews

**A Practical Handbook of Psychiatry for Students and Nurses**, by Louis Minski, M.D. 136 pages. British Book Service (Canada) Ltd., 1068 Broadview Ave., Toronto 6. 2nd Ed. 1950. Price $1.25.

*Reviewed by Barbara G. Kuhn, Clinical Instructor, Verdun Protestant Hospital, Que.*

This little book contains basic information regarding mental illness. It was written as an introductory text for nurses and other hospital workers. It does not attempt to deal with mental disorders or treatment in detail. The material is presented in a concise, informative manner, almost a summary of various aspects of psychiatry.

The opening chapter on the development of the individual describes the mental mechanisms. The next chapters deal briefly with child psychiatry, the etiology and symptoms of mental illness. There are six chapters on the different forms of mental illness.

The chapter on nursing and general management deals with such basic problems as refusal of food, insomnia, suicide, violence, and impulsiveness. Some opinions are expressed which appear to be those of the author alone—e.g., "Patients suffering from the severer forms of mental disorder should be confined to bed." Also, the author does not seem to be aware of the potentialities of





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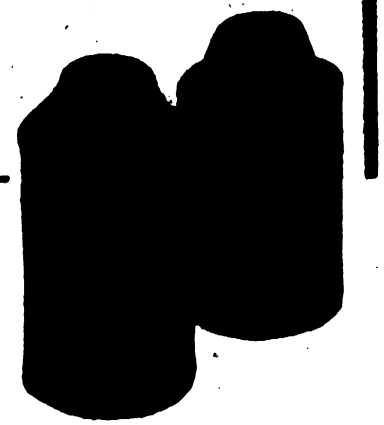

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the nurse in the psychological management of the patient.

There are two chapters on treatment, one each on psychotherapy, occupational therapy, and rehabilitation. All the forms of physical and psychological treatment are described simply. The methods concern a particular institution and may be carried out in a somewhat different manner in other institutions. The importance of occupational therapy and rehabilitation measures are discussed as important adjuncts to treatment.

The last chapter deals with the legal Aspects of Psychiatry in England and Scotland. While this is of interest, it does not apply in Canada.

The book should be useful to students who look for an introduction to the general aspects of psychiatry. There are some excellent definitions and the descriptions of the mental disorders are clear and concise. It is doubtful if they lose anything in descriptive power through their brevity.

**Modern Surgery for Nurses**, edited by F. Wilson Harlow, M.B. 799 pages British Book Service (Canada) Ltd., 1068 Broadview Ave., Toronto 6. 2nd Ed. 1951. Price $5.00.

*Reviewed by Madeline Holmes, Clinical Instructor, General Hospital, St. John's, Nfld.*

This book is designed to meet the needs of student nurses for a reliable text and reference book. It covers the entire field of general surgery and, in addition, there are sections on orthopedics, venereal disease, gynecology, ophthalmic nursing, and anesthesia.

Since the publication of the first edition three years ago, this book has been thoroughly revised. The subject matter is authentic and up to date and is composed of contributions from specialists in the various branches of surgery. The extensive information has been condensed into compact form, yet it is a comprehensive book on modern surgery and surgical procedures. The chapter on heart and chest surgery is very brief and would be more valuable if modern advances in heart surgery had been included.

The book is clearly and simply written and the use of tabulation and heavy type makes it easy to locate and assimilate material. The pictures and explanatory diagrams are excellent and aid in understanding some of the more difficult ideas.

Although more might have been added from the standpoint of nursing care, this book

is a valuable reference and textbook. A comprehensive biblography would also have increased its usefulness.

**Principles of Guidance and Pupil Personnel Work**, by Arthur J. Jones. 630 pages. McGraw-Hill Co. of Canada Ltd., 253 Spadina Rd., Toronto 4. 4th Ed. 1951. Price $6.45.

*Reviewed by Katherine MacLaggan, Assistant to Director of Public Health Nursing Service, Dept. of Health & Social Services, Fredericton, N.B.*

The fact that Principles of Guidance is now available in its fourth edition is a significant comment on its value. With its present revision it has been brought into the spirit of the times. Mr. Jones says in his own preface that "the fourth edition appears at a time when we are nominally at peace but when national rivalries and disagreements are still intense and when the dream of a united world has almost vanished and the spectre of another war is all too evident."

The information on population changes, educational facilities, and things of like nature are American in fact, but bear a similarity to the Canadian situation and problems generally. The Visual Aids Bibliography is valuable and the material here described is available for the most part through our local National Film Boards. Phases of Part 10 may not appear to have too great a significance for the Canadian reader but the application and interpretation of the principles involved are obviously valid and useful here.

The philosophy as expressed in the section called Meaning and Purpose of Guidance is applicable to nursing education. Teachers of nursing education are dealing with a group that has already chosen its vocation but within this vocation are the possibilities of many types of work. The nurse needs the benefits of guidance in the choice of her particular sphere of activity. Since it is here stressed that guidance is directed toward the solution of problems of individuals, it is obvious that the principles involved would apply to efforts on behalf of student nurses. The author places a wide interpretation on the term "guidance" and vocational guidance is placed in reasonable perspective in relation to the wide variety of necessary adjustments to life situations. The author calls attention to the fact that the relationship between guidance and pupil personnel work has been stressed.

Every person concerned with the education of nurses will hope that the members of their student body have been guided into nursing through the application of the principles presented by the author of this book.

**An Introduction to Medicine for Nurses**, by Patria Asher, M.D., M.R.C.P. 362 pages. British Book Service (Canada) Ltd., 1068 Broadview Ave., Toronto 6. 2nd Ed. 1951. Price $5.00.

*Reviewed by Elsie Fletcher, Clinical Supervisor, Grace Hospital, Winnipeg.*

The author of this book endeavors to describe medical diseases with the idea of helping the nurse to understand the reasons behind the nursing care and the observations she will make while on the medical ward. This is done very well. It describes fully the physiological background for the signs and symptoms observed and gives a basis for the nursing care prescribed. The book is very interesting to read and the material is up to date. In many instances the action and method of administration of the more common drugs used is included.

The entire field of medicine, including a few of the more common diseases of children as well as a chapter on mental ill-health, is covered. The extensive information has been condensed into compact form and divided into short chapters. The first few chapters, Part 1, deal with the general principles of medical nursing. Part 2 describes the medical diseases and an appendix outlines clearly some of the more common procedures used on a medical ward. The chapters are divided into section with clear, heavily-printed headings. The style and size of print make it easy to read. There are many excellent illustrations and case histories which help in the understanding of the subject matter.

In the preface the author states that the book is intended chiefly for the student nurse, to be read during her months on the medical ward and, in this respect, I believe the author has been very successful. It could easily be used to make the medical experience for the nurse more interesting and educational.

**A Textbook of Chemistry**, by Stella Goostray, R.N., B.S., M.Ed. and J. Rae Schwenck, A.B., Ch.E. 401 pages. The





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Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 6th Ed. 1950. Price $3.75.

*Reviewed by Doris I. Tinney, Clinical Instructor, Calgary General Hospital.*

This text has been revised by the authors to bring it up to date regarding the latest advancements in chemistry, keeping in mind the prime objective of the book, which is to present fundamental principles of chemistry to the student nurse.

The difficulty of condensing this vast amount of material into 401 pages, while still keeping the book interesting and readable, has been well managed. The topics range from the symbols and properties of common elements through nuclear research to organic chemistry and biochemistry. The material is presented in logical sequence, starting with the most basic concepts of chemistry and progessing step by step to the more complex study of chemical changes in the human body. The interrelationship between chemistry, physiology, nutrition, and pharmacology has been stressed throughout the book, making it especially interesting for nurses. In some areas the subject matter becomes rather too detailed and complex for the average student nurse. To effectively teach the material contained in this book would require a well equipped chemistry laboratory as well as a generous allotment of time in the teaching program.

A valuable feature of this edition is the arrangement of each chapter. The chapter is introduced by a survey and an outline and is closed by a summary, questions and exercise. This arrangement helps to stimulate interest in the forthcoming material and gives a better over-all picture of the topic to be discussed.

Whenever possible the authors have related chemistry to nursing. This is one of the chief advantages of this book over the average text in chemistry. Because of this and because there is a great deal of worthwhile information contained in it, this book deserves a place in a reference library in the school.

**Your Health**, by Dean Franklin Smiley, A.B., M.D. and Adrian Gordon Gould, Ph.B., M.D. 555 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1951. Price $4.50.

Written primarily as a text for the youth who flock to our universities in such numbers, this book is a useful source of information for adults of all ages. It would be a valuable aid to nursing students as they launch into their training. Their informal health teaching at bedsides would take on greater meaning and reliability.

Student nurses' personal health practices should be improved if the precepts laid down here are followed. Rather than dogmatically saying "you must do thus and so to maintain good health," the material includes logical explanations, developed by careful research, of most of the points covered. The chapter on sleep is a good illustration. After discussing the sleep habits of infants and children the authors wrote: ". . . Young adults, as represented by university students, averaged only 7.47 hours of sleep per night. This amount might well be sufficient for a large number of students but, to meet positive health standards and to maintain maximum efficiency with generous reserve, a sleep schedule of eight or nine hours would, we believe, more nearly meet the needs."

The material throughout is of a similar calibre. This book is recommended as being suitable as a required text for the health course given to student nurses.

Orthopaedic Nursing, by Mary Powell, S.R.N. 400 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1951. Price $4.75.

*Reviewed by Mrs. Mary E. Jamison of Alberni, B.C.*

This book is written by an orthopedic matron who has worked and studied under a master, Sir Reginald Watson Jones. She has learned well the art of tricks of orthopedic nursing and the more difficult art of passing on her knowledge to others in a concise and interesting manner. Her writing style is excellent.

Though the book is intended for nurses in post-graduate orthopedic training, it is also useful for graduate nurses or nurses in training who are dealing with orthopedic cases to a lesser degree. The basic principles of orthopedic nursing are set out in a very orderly manner and cover well the many small points which make for the comfort of the patient, as well as the major items of care. These basic principles will be of interest to any nurse and will greatly improve the handling of orthopedic cases.

The more specialized techniques are described in detail. It is here that the book will be of more interest to those nurses specializing in that field. We may find that the techniques used here differ from those in England. For instance, there is no mention of the Bradford frame so well known here, its place being filled by the Thomas straight frame which we see much less commonly. However, the nursing procedures of one usually can be applied to the other without difficulty.

I recommend the book highly. It is easy to read and is a mine of valuable information. I am sure it has few equals in its field.

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It is estimated that the total number of sweat glands in the human body exceeds 2,000,000 and that the total length of the uncoiled glands would approximate eight miles.

Several factors other than environmental temperature changes may produce sweating.





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Muscular exercise, emotional stress, mental activity, asphyxia, certain chemicals, pain and other sensory stimuli are among factors of importance.

Body heat is dissipated by radiation, convection and evaporation of sweat. The latter is one of the most important means by which body temperature is maintained. So essential is loss of heat by vaporization of sweat in hot weather that serious results may ensue from failure to drink enough water. A moderate water deficiency does not decrease sweating; only in severe dehydration is there an appreciable arrest. Similarly, excessive intake of water does not affect the rate of sweating. However, the ingestion of sodium chloride decreases sweat when the salt intake exceeds its loss in the sweat.

## What Does I.Q. Mean?

The term "I.Q." does not deserve all the notoriety it has received. The popularity it has earned is due partly to its high degree of slang effect. The French are known for their idioms and the Americans for their slang. The whole nation says "okay" and now most of the population is using "Ique" as freely. Magazine articles question the matrimonial or decorating ability of their readers with such topics as "What is your Decorating I.Q.?" Kindergarten children come home from school stating that they "had an I.Q. test today" to determine their readiness for entrance in first grade where instruction in reading is begun. Doctors even suggest to the parents of their patients that they should arrange for an I.Q. test for the youngsters. They may be seeking knowledge of the child's social adaptability. If so, the Social Quotient, or S.Q., is significant. Or they may question his developmental rate, which can be expressed by the Developmental Quotient or D.Q.

In cases of selective brain injury, information may be desired about the child's particular constellation of intellectual factors, his special abilities, and deficiencies. This status is described by the factor ages from which the Factor Quotient, or F.Q., is computed. In another instance, the contrast between his performance score and his verbal

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score may be illuminating. Again, personality or interest ratings may be sought. But the public, loving a catch-phrase, talks about the I.Q. as if it were a blanket description of all such psychological investigatory results.

Carefully interpreted, the I.Q. means Intelligence Quotient only. It can be used synonymously with general rate of mental growth. In this respect it could be said that each of us has an I.Q., whether or not it has been measured, just as each of us has height and weight, even if these figures have never been determined.

Certain well standardized intelligence test scales consist of numerous test items, each of which has an age-level designation. For instance, in one such scale, the ability to tie a knot, copy a square, and count four objects is ascribed to Year V, because, in the process of standardization of the scale, it was discovered that the majority of five-year-old children can, without special training, perform these tasks. Should your five-year-old child accomplish these and other assignments of the same level of difficulty and easier but be unable to succeed with any items at a more difficult level, we would say that he has an I.Q. of 100, which is normal. His rate of mental growth is average; he is developing intellectually like others of his age.

It is as important to have knowledge of your child's relative mental ability and developmental status as it is to know his temperature when he has a serious illness. Your ignorance of his condition in either circumstance will not protect him, or you, from the outcome.

Your child is either bright, or normal, or slow mentally, or in any gradation of these categories. In any event, the educational or training facilities provided him should fit his needs which are based on his status. A rapid learner needs enrichment of curriculum in school, in contrast to the limited course of study required by a slow child.

*—The Crippled Child*

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Oliver Wendell Holmes said, "Life is maintained by the respiration of oxygen and of sentiments." As we apply this to geriatrics we can agree that to preserve life with the oxygen tank is useless if we are not prepared to make the life worth living with the vial of compassion.





## Nursing Industriel

*(Suite de la page 907)*

de chambres de toilette, de lavabo, ainsi de suite. Dans tout ceci, combien avons-nous de problèmes à signaler? Il arrive souvent que là ou il devrait y avoir quatre toilettes il n'y en a qu'une. Ces standards sont parfois difficiles à faire observer pour différentes raisons invoquées et l'infirmière ne saurait s'imposer sans dévier de ses attributs.

(c) La nutrition mérite une part d'attention de l'infirmière. Nous savons que les déficiences alimentaires ont des effets désastreux sur la santé. Le caféteria est inspecté périodiquement ainsi que les aliments. Si quelqu'employé fait un rapport malveillant, immédiatement l'infirmière fait enquête et, s'il y a lieu, invite les membres du Comité de Sécurité à donner leur opinion.

L'infirmière essuiera de nombreuses difficultés. Elle peut donner certains conseils comme, par exemple, suggérer la consommation du lait au lieu des liqueurs douces, etc. De même elle conseillera du lait pasteurisé. Mail il est très difficile de changer les habitudes alimentaires de certaines gens. De plus l'infirmière n'est pas spécialiste en nutrition. Elle doit donc regarde d'entrer nutrition. Elle doit donc regarder d'entrer dans trop de détails.

*(La suite au prochain numéro)*

## Employment for Older Workers

There is no clear correlation between chronologic age and performance; disability depends rather on personal factors and on recognizable disease than on number of years. In some areas of human endeavor, as in statesmanship, finance, and many professions, performance increases with age; in others the peak of performance comes relatively early in life. In a tight labor market many who are past the retirement age are found employable and constitute a manpower reserve that can be kept at its best by part-time employment.

*—The American Journal of Nursing*

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Take note of the thought behind these words of an old Indian prayer:

"O Great Spirit Maker of Man, forbid that we judge any man until we have walked two moons in his moccasins."

**THE BRITISH COLUMBIA CIVIL SERVICE** ***requires—***

**REGISTERED NURSES FOR GENERAL STAFF DUTY FOR THE DIVISION OF TUBERCULOSIS CONTROL**

***Willow Chest Centre & George Pearson Unit***—Two hospitals located in Vancouver. All major services & student affiliation course. Registration in B.C. required *Gross Salary:* $210.00 per mo.; annual increments of $5.00 per mo. (over 6-yr. period), rising to $245. No residence accommodation.

***Tranquille Unit***—350-bed T.B. Hospital, located 12 miles from Kamloops in southern interior. All major services except student affiliation. *Gross Salary:* $218.00 per mo. rising to $250 per mo.; annual increments of $5.00 per mo. (over 6-yr. period). New modern residence —attractive bed-sitting rooms. Recreational facilities. Maintenance deduction: Room $5.00 —laundry $2.50. Excellent food at 30c per meal.

*Conditions—All Units*—8-hr. day; 5½-day wk., rotating shifts. 4 wks. annual vacation with pay plus 11 statutory holidays. Sick leave, 18 days per yr. (12 cumulative). Promotional opportunities. Superannuation.

*Write for information & applications to:*

**Supt. of Nurses in respective Units or to Personnel Assistant, Division of T.B. Control, 2647 Willow St., Vancouver 9, B.C.**

**THE BRITISH COLUMBIA CIVIL SERVICE** ***requires—***

**PUBLIC HEALTH NURSES, GRADE 1**—(for the Dept. of Health & Welfare, Province of British Columbia).

***Salary:*** $233 rising to $276 per mo. Promotional opportunities available for *Public Health Nurses, Grade 2* — $250 rising to $303 per mo.

***Qualifications:*** Candidates must be eligible for registration in British Columbia and have completed a University degree or certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province; cars are provided.) Further information may be obtained from the *Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria.*

● Candidates must be British subjects, under 40 years of age, except in the case of ex-service women who are given preference. Application Forms obtainable from all *Government Agencies, the Civil Service Commission, Weiler Bldg., Victoria,* or *636 Burrard St., Vancouver 1,* to be completed & returned to the

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The following one-year certificate courses are offered:

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- Course begins ***Aug. 25, 1952, Jan. 12, 1953,*** and ***May 4, 1953.*** Enrolment limited to a maximum of eight students.

*For further information write to:*

**Supt. of Nurses, General Hospital, Winnipeg, Man.**

## Victorian Order Of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments — Arnprior-Braeside, Ont,: *Catherine Moore* (Montreal Gen. Hosp. and McGill University) as nurse in charge. Dartmouth, N.S.: *Daphne Harnett* (King Edward VII Memorial Hosp., Bermuda). Fort William: *Winnifred Tasker* (Victoria Hosp., London, and University of Western Ontario) as nurse in charge. Hamilton: *Mary Gibbon* (Hamilton Gen. Hosp. and University of Toronto) and *Mary McCallum* (Royal Alexandra Infirmary, Scotland, and Edinburgh University). Kitchener, Ont.: *Mrs. Beverly Read* (H.G.H.). Lachine, Que.: *Denise Guimond* (St. Joseph's Hosp., Lachine, and University of Montreal). New Glasgow, N.S.: *Anne Pask* (Wellesley Hosp., Toronto, and University of British Columbia) as nurse in charge and *Mrs. Frances Thompson* (Aberdeen Hosp., New Glasgow). New Liskeard, Ont.: *Hazel Thompson* (Guelph Gen. Hosp. and U. of T.) as nurse in charge. Ottawa: *Carmelle Castonguay* (St. Mary's Hosp., Timmins, Ont.) and *Thérèse D'Aoust* (University of Ottawa School of Nursing). Rouyn-Noranda, Que.: *Marie Claire Muir* (Ste. Jeanne d'Arc Hosp., Montreal, and U. of Montreal). Vancouver: *Eunice Bastable* (Winnipeg Gen. Hosp.), *Mrs. Audrey de Koven* (Misericordia Hosp., Winnipeg), and *Lila Shields* Vancouver Gen. Hosp. and U.B.C.). Woodstock, N.B.: *Hazel Salmon* (Montreal Gen. Hosp. and McGill U.) as nurse in charge.

Transfers— *Grace Fitzpatrick* from Niagara Falls to Ottawa; *Blanche Hillier* from Leamington, Ont., to Chatham, Ont.; *Juanita Keith* from Yarmouth, N.S., to Lockeport, N.S., as nurse in charge; *Catharine Maddaford* from Regina to St. John's, Nfld., as nurse in charge; *Rose Mary McClan* from Montreal to Niagara Falls as nurse in charge; *Beatrice McLea* from Hamilton to Toronto; *Vivian Sharpe* from Liverpool, N.S., to Burnaby, B.C.

Resignations — Arnprior-Braeside: *Mary Wurtele* as nurse in charge. Fort William: *Merle Pringle* as nurse in charge. Lockeport, N.S.: *Lorna Conrad* as nurse in charge. North York, Ont.:*Catherine Ferguson.* Owen Sound, Ont.: *Jane (Dunfield) Ouelette* as nurse in charge. Sarnia, Ont.: *Mrs. Edna McDougall.* Saskatoon: *Mrs. Vivian Menzies.* Toronto: *Eileen Carson, Amy Eacott, Ann McKinnon,*





*Katherine Tuttle, Mmes Marilyn Lipsit* and *Phyllis Rayner.* Vancouver: *Mrs. Janet Couldwell.* Victoria: *Jean Allan.* West Vancouver: *Elizabeth Robertson.* Winnipeg: *Elly Olive Enns.* Woodstock, N.B.: *Mrs. Sheila Dibblee* as nurse in charge.

## Lip Reading

The tragedy of deafness lies in the loss of the sound of the human voice. The work of lip reading is to stimulate the memory of speech with the feeling and seeing forms and to help them to replace the lost physical sound. The work of the hearing aid is to amplify the sound, as far as the hearing disability will allow. Lip reading is a mental and physical effort, involving memory and natural conditions.

The deafened child turns instinctively to lip reading, absorbing what he needs in order to associate thought and speech. Eventually he may develop into a "natural" lip reader without understanding what he is doing. A doctor, when testing children's hearing, will not let them see his face, lest they lip read, instead of hearing what he says.—*The Hearing Eye*—Spring, 1950.

## The Handicaps of Overweight

Overweight is harmful for a great variety of reasons. It not only curtails longevity, but it seriously handicaps individuals in other and subtle ways. No age of life is spared; men, women, and children alike are effected.

The adverse effects on health are the major penalties of overweight. To a certain degree, this is reflected in the lessened ability to withstand medical and surgical emergencies. For the most part, however, the effects creep up stealthily, and they do not show up until the individual is fairly well along in life. It is for this reason that it is necessary to stress the prevention of overweight through the establishment of good dietary habits in childhood.

Today when the chief germ enemies of mankind are coming under control in most Western nations, the degenerative diseases stand out as the principal causes of chronic diseases and disability. Evidences are numerous that overweights suffer more frequently and earlier from these conditions than do persons of lighter build. Hypertension, or high blood pressure, degenerative heart dis-

**MEDICAL NURSING**

*By Edgar Hull and Cecilia M. Perrodin.* This widely-used textbook includes recent medical and nursing advances. New material covers skin diseases (two new chapters), diseases of the nose, throat and mouth, infectious diseases. 844 pages, 172 illustrations, fourth edition, 1952. $5.50.

**SURGICAL NURSING**

*By Robert K. Felter, Frances West, and Lydia M. Zetzsche.* A popular textbook with both students and instructors. Includes new treatments developed by war experience, new units in Orthopedics and Surgery of the Eye, Ear, Nose and Throat. 700 pages, 385 illustrations, sixth edition, 1952. $5.50.

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* Administration and Supervision in Public Health Nursing.

Supervision in Psychiatric Nursing.
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Supervision in Paediatric Nursing.

eases, associated with arteriosclerosis and hypertension, are likewise more frequent in overweights.

Diabetes is perhaps the most striking penalty of overweight. Analysis of the weights of thousands of diabetic patients of the George F. Baker Clinic showed that among those whose disease began at ages 40 and over, 85 per cent previously had been overweight in some degree and 60 per cent markedly overweight.

In the popular mind, no condition is more characteristic of overweight than gallstones and other disorders of the biliary system. The common adage about gallstones—Fair, Fat and Forty—holds true, except that a dark complexion is no protection against them.

The relationship between overweight and cancer is not clear cut, but cancer of the endometrium appears to be definitely more frequent in overweight women than in those of lighter weight.

It is clear that overweight profoundly affects the life and health of many individuals. The exact nature of the relationships between overweight and many of the conditions mentioned is not always clear. The extra burden that overweight puts on various organ systems of the body is primarily mechanical. Overweight may also reflect disturbances in body chemistry. Much research is being devoted to this aspect of the matter. In any event the correction of the obesity may prevent or delay the onset of these conditions if reduction is begun early. Even after their development, weight reduction can help. For example, it is of major importance in treatment of obese persons with degenerative heart disease or with hypertension.

The solution of the problem of overweight, which now is so important in the national health picture, is not easy, although the principle involved is simple—namely, cutting down the amount of food consumed by fat people. The major difficulty lies in the fundamental psychological factors behind overeating. Fortunately, increased attention is being given by physicians and health educators to this aspect of the problem, and new methods, such as group therapy, are being developed and tested which aim at helping overweights obtain insight into the underlying cause of their condition. Once this is accomplished, the chances are better for obtaining the patient's cooperation in sustained efforts to bring and keep his weight down.

*—M.L.I.C. Statistical Bulletin*



# News Notes

## ALBERTA

JASPER

A regular meeting of Edith Cavell Chapter was held at the home of Mrs. McCague with 12 members present. It was planned to hold a first aid course in conjunction with the St. John Ambulance. If interest warrants it, the Baby Clinic will be reopened at the beginning of next year.

## BRITISH COLUMBIA

KAMLOOPS-TRANQUILLE

The following officers are serving for the Kamloops-Tranquille Chapter: President, Mrs. I. McQuay; vice-president, M. Rowles; recording and corresponding secretaries, S. Strong, K. Stewart; treasurer, Mrs. K. E. Nicholson. Committees: Public health nursing, Mrs. N. McFarlane; general nursing, Mrs. Manson; membership, Mrs. W. R. Waugh; program, Mrs. Humphreys; visiting, O. Garrood, E. Morton; scholarship, E. Driedger.

A party with a unique theme was held last spring when the members of the 1952 class of the Royal Inland Hospital School of Nursing were guests of the chapter. An East Indian effect was carried out with the guests and members dressed as dancing girls, slaves, guards, while O. Garrood came as the sultan. Prior to the dinner at the Valleyview Drive-Inn, a cocktail party was held at the home of Mrs. A. L. Clarke. The dinner was served in the manner of the Oriental countries, guests sitting on cushions on the floor. Music, incense, and decorations all added to the atmosphere. Three members, dressed as "mummies," entertained with songs. Miss Garrood read excepts from "The Rubaiyat of Omar Khayyam." C. E. Guillod, superintendent of nurses at R.I.H., addressed the graduates, Miss Garrood welcoming them to the chapter. Gifts were presented to the graduating class on behalf of the members.

The *Kamloops Sentinel* and Radio Station CFJC are most cooperative in advertising meetings and projects of the chapter.

Plans are under way for another rummage sale, previous ones having been held for the past two years.

## MANITOBA

VIRDEN

From Terrace Bay, Ont., Dorothy Wilson was welcomed as the new matron of the local hospital. She is a graduate of the Children's Hospital, Winnipeg.

## NEW BRUNSWICK

MONCTON

*Nurses' Hospital Aid*

At a recent meeting, with Mrs. J. Innes, vice-president, in the chair, it was decided to hold a rummage sale and cooking sale. Mrs. E. G. McConnell gave the Rolling Dollar to Mrs. G. Cooper and Mrs. Nash-Smith won the Mystery Box.

*In Ontario contact your local registry for further information and samples.*

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If you require special measurements, we will tailor them in orders of not less than three, at a nominal charge.

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*For particulars apply to Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.*

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*Apply to:*
**Chief Superintendent,**
**Victorian Order of Nurses for Canada,**
193 SPARKS STREET,
Ottawa 4, Ont.

## NOVA SCOTIA

### HALIFAX

*Victoria General Hospital*

Maisie Miller, superintendent of nurses, was the guest of honor at a tea given for her by the alumnae association. Miss Miller, who will attend the University of Toronto School of Nursing for a year, was presented with a gold pin by the president, Mrs. T. Carpenter, on behalf of the alumnae. Tea was poured by M. Ripley and F. Fraser, the convener for this event being J. Elliott.

## ONTARIO

### DISTRICT 4

ST. CATHARINES

Rita Brown, vice-chairman, conducted a meeting of Niagara Chapter held at Hotel Dieu residence in September. D. Sharpe outlined the formation of a new Civil Defence Committee and it was decided to make this a project of the Niagara nurses for the coming year. It was reported that five instructors from this district have completed the five-day course in Civil Defence held at the University of Toronto School of Nursing. T. Finlayson who attended this course gave a brief report, stating that 74 nurses had registered with 34 centres represented.

The highlight of the evening was a pictorial report of Quebec City along with a commentary by the talented photographer, Miss Sharpe. At the conclusion of the slides, the Sisters served a delicious lunch.

### DISTRICT 5

TORONTO

*General Hospital*

The 70th class to graduate from the School of Nursing held their banquet and dance at the Royal York Hotel. This was the largest class ever to graduate here and, with one exception, all were present at the gala event. One hundred and twenty-one students and seven guests from the staff rose to drink the toast to the Queen. M. Balmer said grace, M. Noble acting as toast-mistress. Toasts to the school and staff were proposed by M. Willis and M. Hope. At the head table were: Misses Macfarland, Ives, Balmer, Leavens, Matheson, Thompson, Jennings, Noble, A. Watson, B. Hope, Willis, M. Moreland, and D. White. The valedictorian was A. Watson.

The alumae was "At Home" for the 1952 class and their mothers. The guests were received by Marie (Breithaupt) Martin, alumae president; Misses Macfarland, Ferguson, and Noble. Those presiding at the tea-tables were: Mmes Burns, McCutcheon, McClelland, W. R. Campbell, Bedford, Culley, Jeffrey, Gill, Misses Snyder, Williams, S. Holmes, and Rendall.

At the annual garden party, held by the alumnae in the hospital grounds, Mrs. Breithaupt, the wife of the Lieut. Governor, officiated at the opening. Approximately $1,400 was realized from this event.

The following graduates are taking university courses as follows: McGill—J. Forrest; Toronto—R. Edwards, L. Fauteux, E. Flaxman, A. Moore, J. Laughren, J. Marsh, M. Porter, J. Lorenz, M. Cameron, M. Horne, L. Hilditch, N. McFarlane, A. Baird, M. McRae, E. Walker, M. Wood; Western Ontario—M. Harris, A. Voaden.

J. Le Pan, formerly at Johns Hopkins Hospital, Baltimore, is now at T.G.H. as clinical instructor on Ward A, while H. McLaren is instructing on Ward G. J. Murray, formerly head nurse, Ward A, has transferred to the clinical instructors group in the Dunlap Bldg. E. Monaghan is head nurse in B.O.R. D. Jackson is finishing her third year at Bible School, Victoria, and looking forward to medical missionary work with the Sudan Interior Mission in Africa. Cora Kilborn is on the staff of the General Hospital, Lachine, Que. A. Cameron, having completed a year of study at the School of Social Work, will spend a year on the Continent. T. Green has returned from the 13th biennial conference of the Federation of Business and Professional Women's Clubs. She is helping with the work of Civil Defence and is also speaking on behalf of the Jury Duty Committee of the B. & P. Women's Clubs. J. Lorenz is at the Sarnia General Hospital. L. Clemens and G. Walker are with *H.M.C.S. Cornwallis*. N/S V. Geer is at Aylmer with the R.C.A.F. while J. Johnson and I. Hillman are with the air force at Rockcliffe. S. (Hunt) Hunking is at Mokwa, Nigeria, B.W.A. D. James is at Johns Hopkins Hospital. E. (Willson) Jeffs is with the Napanee Co. health unit. J. VanMeer is back at T.G.H. A. White is at the General and Marine Hospital, Collingwood.

### DISTRICT 10

PORT ARTHUR

The General Hospital School of Nursing Alumnae Association entertained members of the 1952 graduating class and their escorts at a dance in August. In the receiving line were: Mr. and Mrs. J. Lowcock, the latter representing the alumnae; Mr. D. P. Peart, administrator, and Mrs. Peart; K. Feisel, director of nursing; and Alice Hunter, assistant superintendent. A toast to the graduates was given by Dr. C. E. Baker. In charge of tickets were Mmes A. Chase and G. Fraser.

## PRINCE EDWARD ISLAND

Lyle Creelman who, for the past three years, has been nursing consultant in maternal and child health with WHO, spoke to a group of nurses and others in September. She told of the organization of WHO and the five regions making up the member countries. She spoke of the nursing teams, composed of one or more doctors and nurses who, when asked by the government of a country to help organize nursing, are matched by an equal number of doctors and nurses in that country. Adjustments must be made in each country when organizing and nursing education is of necessity adapted to the customs, living conditions, and facilities of that country. Miss





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**Director of Nursing**
**Box 6034**
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• Announces a five-month supplementary *Clinical Course* (approved by the New York State Education Department) *for Graduate Registered Nurses* in the nursing care and treatment of diseases of the eye, ear, nose and throat. Operating room training is included in the course.

• During the entire period the student will receive a monthly stipend of $80 and full maintenance.

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**210 East 64th St.**
**New York City 21, N.Y.**

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Creelman emphasized the point that the policy of the nursing team is to teach and train leaders in the country seeking help in order that they may carry on. She also emphasized the need of integrating public health all through the nursing course. An account of Miss Creelman's trip from Geneva, through Egypt, India, Burma, and Ceylon, was heard with interest.

*Charlottetown Hospital*

Mrs. C. Trainor, president, was in the chair at a meeting of the alumnae association. It was decided to donate $25 to the hospital bazaar and a dance was also planned, part of the proceeds to go towards the Mary Catherine Foot Fund. A very enjoyable social evening was spent at the summer home of Mrs. Trainor when a sing-song was held around a beach campfire and wieners were served.

*Prince Edward Island Hospital*

The annual meeting of the alumnae association was held recently, with Mrs. H. Willis, the president, in charge. The following officers were elected for the coming months: President, Mrs. L. Vatcher; vice-president, K. Williams; secretary, Mrs. W. W. MacEachern; treasurer, Miss F. MacMillan.

## QUEBEC

MONTREAL

At the end of September a tea was held by *The Canadian Nurse* in honor of Catherine Perkins who has been appointed assistant editor and field representative for the *Journal*. This enjoyable event was held in the nurses' home of St. Mary's Hospital. M. E. Kerr, the editor, and Sr. M. Felicitas, director of nurses at the hospital, and a member of the *Journal* Editorial Board, received the guests. M. Birnie, F. Kuzniak, Mmes F. Toohey and K. English, staff members of the *Journal*, assisted at the tea-table and with the serving.

*General Hospital*

At a regular meeting of the alumnae association, Mmes P. Read and E. Crawford gave a splendid joint report on the C.N.A. convention held in Quebec City.

A staff tea was held at the Western Division in honor of Clara Gas who is retiring after 30 years' service with the Social Service Department. She was presented with a china tea-set and a lamp.

## SASKATCHEWAN

SASKATOON

*St. Paul's Hospital*

The opening of St. Paul's Hospital clinical year and school of nursing new term coincided with Saskatoon's 70th anniversary celebrations. As the city's first hospital (1907) and first school (1909), St. Paul's is numbered among its pioneers. First official function of the new term was the welcoming of 40 Freshmen B. Introductions were led by M. Linwood (3B), school president. The M.C. was J. Ratzlaff (3A), president of the Cultural Committee.

September saw the inauguration of the Block System of education at St. Paul's. Faculty members include: F. McDonald, educational director; G. Brkich, science instructor; M. Mackenzie, nursing arts coordinator; M. Cook, assistant nursing arts instructor; Mmes Howe, Mahoney, Miss Funk, clinical instructors; Miss McNaughton (obstetrics) and Miss Fedoruk (pediatrics), clinical instructors; A. Cole, health nurse; D. Webb, physical education instructor.





**CANADIAN RED CROSS SOCIETY**

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*Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.*

Supt. for 50-bed hospital. Must be well qualified person. Salary open. Apply, stating qualifications, experience & reference, Administrator, Wrinch Memorial Hospital, Hazelton, B.C.

General Duty Nurses for modern 50-bed hospital. Gross salary: $215 less $40 board & lodging. $10 annual increase. 10 statutory holidays. 4 wks. annual vacation. 1½ days sick leave per mo. cumulating to 36 days. Transportation allowance not exceeding $60 refunded after 1st. yr. Apply Administrator, Wrinch Memorial Hospital, Hazelton, B.C.

Director of Public Health Nursing for Dept. of Health, City of Ottawa. Staff of 22 nurses & 4 supervisors. Generalized public health nursing program. Apply Dr. J. J. Day, Medical Officer of Health, Transportation Bldg., 48 Rideau St., Ottawa 2, Ont.

Matron for new 17-bed Municipal Hospital. Easy access to Calgary & Edmonton. Pleasant working conditions. 1 mo. vacation with pay after 1 yr. of service. All statutory holidays. Sick leave time paid for if not used. Transportation refunded after 6 mos. service. Minimum salary: $195 per mo. less $20 for full maintenance. Splendid opportunity for nurse to gain administrative experience leading to better position. One General Duty Nurse can be used if two girls wish to travel together. Apply Sec.-Treas., Municipal Hospital, Elnora, Alta.

Nursing Arts Instructor & Asst. Supervisor for Operating Room for 450-bed General Hospital with 150 students. Apply Director of Nursing, General Hospital, Saint John, N.B.

Asst. Supervisor for Children's Dept. in large General Hospital in vicinity of Toronto. Apply, giving qualifications & experience, c/o Box B, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Clinical Instructor. Salary determined by qualifications. Apply Director of Nurses, St. Joseph Hospital, Mt. Clemens, Michigan.

Night Supervisor (1) & 3-11 Supervisor (1) for well equipped 70-bed hospital with all graduate staff. Must be capable of taking charge in delivery & operating rooms. Salary: $170 per mo. plus full maintenance. Annual increases. Apply Supt. of Nurses, Douglas Memorial Hospital, Fort Erie, Ont.

Administration Asst. in Nursing. Beginning salary: $14 per day. Apply Director of Nurses, St. Joseph Hospital, Mt. Clemens, Michigan.

Registered Nurses for St. Joseph Hospital, Mt. Clemens, Michigan, 25 miles north of Detroit, near Selfridge Air Force Base. Optional 40- or 44-hr. wk. Staff Nurses: $12 day duty; $13 afternoon or night duty. State Standards. Apply Director of Nursing Service.

Night Supervisor, General Duty Nurses, Registered & Grace Maternity Graduates, Laboratory Technician. Apply, stating experience, Supt., Queens General Hospital, Liverpool, N.S.

Asst. Dietitian (qualified) for 225-bed hospital. Apply Chief Dietitian, Moncton Hospital, Moncton, N.B.

## ANESTHESIA

A career specialty for the Graduate Nurse. ***Eligibility:*** Graduates of Accredited Schools of Nursing. ***Course:*** Study of the basic sciences related to Anesthesia. Clinical training in all phases of General Anesthesia, Resuscitation, and Inhalation Therapy. ***Professional Opportunities:*** Full-time position in teaching and non-teaching hospitals in United States. For special course write: **Mary H. Snively, R.N., In Charge of Nurses' Training Programs, Duke Hospital, Durham, North Carolina.**

**Operating Room Supervisor.** Mature person with wide experience in O.R. service. Post-graduate study desirable. Salary open. Annual increments, vacation, sick time. 48-hr. wk. Will pay travel expenses for personal interview. Also **Evening Nursery Supervisor** with experience in obstetrics. Post-graduate study desirable. Salary depends on qualifications & past experience. Additional increment for evening duty. Expenses for personal interview. Hrs., etc., as above. **General Duty Nurses.** Salary: $162.50 per mo. for new graduates. 2 meals, laundry, 8-hr. day, straight shift. $15 differential evenings; $10 nights. Vacation, sick time, statutory holidays, annual increments. Financial recognition for university, post-graduate work or yrs. of experience. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

**Operating Room Supervisor** (special preparation preferred). Also **Dietitian & Night Supervisor** for 100-bed hospital. Salary depends on qualifications & experience. Apply Soldiers' Memorial Hospital, Campbellton, N.B.

**Vancouver General Hospital** invites immediate inquiries from **Graduate Nurses** for Staff Vacancies. Salaries: $222 as minimum & $258 as maximum per mo. plus shift differentials for evening & night duty. Employee benefits include: 44-hr. wk; 11 public holidays; 4 wks. vacation; 1½ days per mo. cumulative sick leave; pension plan if under 35. Acceptable qualifications for registration in B.C. necessary. Apply Director of Nursing, General Hospital, Vancouver 9, B.C.

**Nurses** for all shifts in Psychiatric Hospital. Temperate climate year round. Citizenship not necessary to register in state. Pleasant surroundings. 40-hr. wk. Days off together. Overtime paid for any extra hours worked. Annual leave, sick leave & paid holidays. Social Security & pension plan. **Supervisors.** 8 needed. Starting salary: $3,092. 3 yrs. experience, one of which must have been in psychiatric field. **Head Nurses.** 10 needed. Starting salary: $2,732 1 yr. of experience. If desired, complete maintenance at nominal charge. Some private baths. State registration necessary. Apply Isabel M. Reardon, R.N., Supt. of Nurses, Western State Hospital, Staunton, Virginia.

**Registered Nurses** (white) for 100-bed General Hospital. 3 shifts. Excellent salary. 6 paid holidays. 12 paid sick days per yr. 2-wk. paid vacation after 1 yr. service. Apply Director of Nursing, Zieger Osteopathic Hospital, 4244 Livernois, Detroit 10, Michigan. (Phone TA 6-6400).

**Registered Nurses:** General Duty (3) $260 per mo. **Operating Room Scrub Nurse** (2) $270 per mo. Annual increase of $10 per mo. 8-hr. day, 40-hr. wk. Paid vacation — 2 wks. after 1st yr., 3 wks. after 3 yrs., 1 mo. after 5 yrs.; sick leave cumulative to 30 days. Quarters in nurses' home available at $20 per mo. Train fare refunded after 1st yr. of employment. Hospital is 155-bed General Hospital located in Fresno, California, in the heart of San Joaquin Valley, convenient to San Francisco, Los Angeles, Pacific Ocean beaches & many national parks. Several Canadian nurses are presently employed in this hospital as well as other hospitals in vicinity. Write for application form & visa information to C. H. Linville, Administrator, Community Hospital, 1234 "S" St., Fresno 1, California.

**General Staff Nurses** will find real opportunity to realize their ideals in our 337-bed Teaching Hospital with University affiliation. Community offers unlimited choice of cultural & recreational facilities. 40-hr. wk. 3 wks. vacation. Paid sick leave. Rotating shift $1.30-1.40 per hr. Differential of 10 cts. per hr. for evening & night shifts. Apply Director of Nurses, Evanston Hospital, 2650 Ridge Ave., Evanston, Illinois.

**Registered Nurses** for General Duty Staff. Salary commences at £37-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.





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**The Indian Health Services of the Department of National Health & Welfare** require ***Registered Nurses & Licensed Practical Nurses*** for Hospital, fully modern Outpost Nursing Stations & Public Health Nursing positions.

*Beginning Salaries* — ***Registered Nurses,*** $2,300-2,720. ***Licensed Practical Nurses*** with 2 yrs. experience, $1,920-2,220. 44-hr. wk. 3 wks. leave with pay annually plus additional 12 days leave with pay in isolated areas. Educational opportunities.

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**General Duty Staff Nurses** for 515-bed General Hospital. Beginning salary: $230 per mo. with advancement to $250. $20 additional for evenings & nights. 40-hr. wk. Hospital & school of nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

**General Duty Nurses** for 680-bed General Hospital with School of Nursing. Beginning salary: $258; increase to $273 at end of 6 mos. employment. $15 increase 1 yr. after 1st increase. Differential of $10 for special services & p.m. & night duty. 40-hr. wk. 11 paid holidays. 3 wks. vacation. Free laundry. Cumulative sick leave. Temporary housing available. Apply Director of Nursing Service, General Hospital, Fresno, California.

**University of Alberta Hospital** invites applications for **General Staff Duty.** Salary: Minimum $202 & maximum $230 per mo. 44-hr. wk. 3 wks. vacation annually. 11 statutory holidays. Cumulative sick leave. Pension plan & group insurance. Blue Cross. Consideration given to request for service in following depts: General medicine, medical specialties, general surgery, surgical specialties, pediatrics, obstetrics, operating room. Cost of railway ticket to Edmonton refunded after 1 yr. continuous service. Apply Supt. of Nursing Service, University of Alberta Hospital, Edmonton, Alta.

**Graduate Floor Duty Nurses** for General Hospital, Hamilton, Ont. Gross initial bi-weekly salary: $83 plus Cost of Living Bonus of approx. $6.00 per wk. 44-hr. wk. For other perquisites & further information apply C. E. Brewster, Supt. of Nurses.

**Graduate Floor Duty Nurses** for Mount Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $83 plus cost of Living Bonus. For other perquisites & further information apply Supt.

**General Duty Nurses.** Salary: $173.23 (one hundred seventy-three dollars & twenty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day: 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst Ont.

Applications will be received by the undersigned for the position of **Supervising Nurse** for the Kent County Board of Health Unit. Applicants to have qualifications as laid down by Dept. of Public Health, Ont. Applications will also be received for a **Staff Nurse,** qualifications as laid down by Dept. of Public Health, Ont. W. M. Abraham, Sec-Treas., Kent County Board of Health, Kent County Municipal Bldg., 7th St., Chatham, Ont.

**Graduate Nurses** for General Duty. 48-hr. wk., 7 statutory holidays, 3 wks. vacation after 1 yr. service, 2 wks. sick leave per yr. Excellent train & bus service to Ottawa. Apply Supt. Arnprior & District Memorial Hospital, Arnprior, Ont.

**Graduate Nurses** for Floor Duty in modern 50-bed General Hospital. Also **Operating Room Scrub Nurse.** Apply Supt., District Memorial Hospital, Leamington, Ont.

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**Graduate Nurses (2)** for General Duty for immediate future. Starting salary: $200 with annual increments of $5.00 per mo. Full maintenance $40. Statutory holidays paid. 28 days vacation after 1 yr. service. Usual sick leave. Apply Miss A. Naomi Pow, Supt. of Nurses, Slocan Community Hospital, New Denver, B.C.

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**Graduate Nurses** for completely modern West Coast hospital. Salary: $210 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Also **Evening Supervisor** from 4:00 till midnight. Salary commences at $225. Working conditions & perquisites same as nurses. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

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**General Duty Nurses** for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $215-253. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

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**General Duty Nurses (3).** Commencing salary: $220; full maintenance $45 per mo. 44-hr. wk. 28 days annual leave plus 10 statutory holidays. Annual increases & sick leave. Fare advanced if desired. Apply Director of Nursing, General Hospital, Princeton, B.C.

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**General Duty Nurses** for 500-bed Teaching Hospital with well planned rotation schedule. Salary: $210 per mo. gross plus annual increments for 4 yrs. B.C. registration required. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

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**General Duty Nurses** immediately for Trail-Tadanac Hospital, Trail, B.C. Personnel practices as outlined by Reg. Nurses' Ass'n. of B.C. Apply Director of Nursing.

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**General Duty Graduate Nurses** for 60-bed General Hospital, situated 150 miles northeast of Vancouver on B.C. coast. Salary $222 per mo. less $25 for complete maintenance & laundering of uniforms. 4 wks. holiday with pay plus 10 statutory holidys. Transportation advanced if desired. Apply Matron, St. George's Hospital, Alert Bay, B.C.

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**Graduate Nurses** for 175-bed Tuberculosis Sanatorium near Prince Rupert. Salary for General Duty, $232 per mo. plus yearly increases. Room, board, laundry at $30 per mo. Transportation refunded on promise of 1 yr. service. Apply airmail, giving full details of experience, Matron, Miller Bay Indian Hospital, Box 1248, Prince Rupert, B.C.

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**Nurses (2)** for 24-bed hospital & nurses' home both up to date & modern. Salary: $175 per mo. with full maintenance. Usual holidays with pay, sick leave, etc. Transportation refunded if nurse stays a yr. or longer. Apply Matron, Union Hospital, Vanguard, Sask.

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**General Staff Nurses** for newly constructed hospital. Starting salary: $175 per mo. plus $10 differential for afternoon duty. Additional pay for post-graduate study & operating room technique & obstetrics. Good personnel policies. Apply Director of Nurses, General Hospital, Guelph, Ont.

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**General Staff Nurses** for 300-bed hospital—medical, surgical & pediatric services. Salaries: $1,620-1,920. Additional $10 per mo. for evening or night duty. Full maintenance provided. Attractive new nurses' residence. For further information apply Director of Nursing, Tuberculosis Hospital, East Saint John, N.B.





**Graduate Nurses for General Staff Duty** in 350-bed Tuberculosis Hospital. For further information apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

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**Registered Nurses for General Duty.** 35-bed active General Hospital, 50 miles from Toronto. Gross salary: $178 per mo. Apply Supt., Lord Dufferin Hospital, Orangeville, Ont.

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**Registered Nurses for General Duty** for small General Hospital. Salary: $140 per mo. with full maintenance. 6-day wk. 8-hr. duty, rotating shifts, 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. 6 statutory holidays. 28 days holiday. Apply Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

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**Educational Director, Night Supervisor, General Staff Nurses for Maternity & General Wards.** School of Nursing, approx. 200 students. Salary in accordance with position & qualifications as recommended by Sask. Reg. Nurses' Ass'n. For further details regarding positions apply Director of Nursing, City Hospital, Saskatoon, Sask.

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**Asst. Director of Nurses, Clinical Instructor & General Duty Nurses.** Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

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**Obstetrical Supervisor & Staff Nurses** for Archer Memorial Hospital, Lamont, Alta. Salary—prevailing schedule. Cost of Living Bonus. 5% increase bi-yearly. 1 mo. holiday at end of each yr.'s service. 8-hr. day, 1½ days off ea. wk. 1 long week-end ea. mo. Time allowed for all statutory holi ays. Apply Supt. of Nurses.

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**Instructor** (qualifi d) to begin duties in July, 1953. Salary: $240 gross. **Head Nurse for Private Wing** (27 beds). Salary: $215 gross. **General Duty Nurses** for Obstetrical, Medical & Surgical floors. Salary: $180-195 gross depending on experience. 44-hr. wk. 2½ days holiday per mo. Half day on statutory holidays. 1½ days sick time per mo., cumulative to 30 days. Charge of $30 per mo. for board & room. Apply Mrs. M. Alexander, Acting Director of Nursing, General Hospital, Medicine Hat, Alta.

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**Matron (1) & Nurse (1)** for Union Hospital, Lucky Lake, Sask. Salaries: $200 & $175 plus maintenance, respectively. Apply G. D. Clark, Sec.-Treas., Lucky Lake, Sask.

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**Head Nurses** for approved 235-bed hospital. Few hours from Portland & Seattle. 40-hr. wk. Paid vacation. Sick leave & Blue Cross. Salary: $255-295 per mo. $20 bonus for P.M. duty; $10 nights; $10 surgery, delivery room & isolation. Apply Director of Nursing Service, St. Elizabeth Hospital, Yakima, Washington.

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**Dietitian** immediately for 85-bed General Hospital in Central B.C. Salary range: $220-240 per mo. Board & lodging available at nominal charge. Apply Prince George & District Hospital, Prince George, B.C.

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**Registered Nurses** with Public Health training & experience, preferably generalized. Not over 35 yrs. of age. Initial salary: $2,700 with annual increment. Pension scheme available. Apply Director, Nursing Service, Ontario Society for Crippled Children, 92 College St., Toronto 2, Ont.

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**CIVIL SERVICE**
**(FEDERAL)**
**HOSPITAL NURSES**

GRADE 1—$2,300 - $2,640
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for the Department of Veterans Affairs at Toronto, London, Halifax, Montreal, Ste. Anne de Bellevue, St. Hyacinthe, Winnipeg, Vancouver and Victoria.

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immediate employment at the *Saguenay General Hospital, Arvida, Quebec.* Regular employment. Room and board and laundry service of uniforms provided. Very favorable living and working conditions. Starting salaries commensurate with qualifications and experience.

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**Graduate Nurses (2)** for General Duty for immediate future. Starting salary: $200 with annual increments of $5.00 per mo. Full maintenance $40. Statutory holidays paid. 28 days vacation after 1 yr. service. Usual sick leave. Apply Miss A. Naomi Pow, Supt. of Nurses, Slocan Community Hospital, New Denver, B.C.

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**Graduate Nurses** for completely modern West Coast hospital. Salary: $210 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Also **Evening Supervisor** from 4:00 till midnight. Salary commences at $225. Working conditions & perquisites same as nurses. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

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**General Duty Nurses** for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $215-253. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

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**General Duty Nurses (3).** Commencing salary: $220; full maintenance $45 per mo. 44-hr. wk. 28 days annual leave plus 10 statutory holidays. Annual increases & sick leave. Fare advanced if desired. Apply Director of Nursing, General Hospital, Princeton, B.C.

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**General Duty Nurses** for 500-bed Teaching Hospital with well planned rotation schedule. Salary: $210 per mo. gross plus annual increments for 4 yrs. B.C. registration required. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

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**General Duty Nurses** immediately for Trail-Tadanac Hospital, Trail, B.C. Personnel practices as outlined by Reg. Nurses' Ass'n. of B.C. Apply Director of Nursing.

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**General Duty Graduate Nurses** for 60-bed General Hospital, situated 150 miles northeast of Vancouver on B.C. coast. Salary $222 per mo. less $25 for complete maintenance & laundering of uniforms. 4 wks. holiday with pay plus 10 statutory holidys. Transportation advanced if desired. Apply Matron, St. George's Hospital, Alert Bay, B.C.

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**Graduate Nurses** for 175-bed Tuberculosis Sanatorium near Prince Rupert. Salary for General Duty, $232 per mo. plus yearly increases. Room, board, laundry at $30 per mo. Transportation refunded on promise of 1 yr. service. Apply airmail, giving full details of experience, Matron, Miller Bay Indian Hospital, Box 1248, Prince Rupert, B.C.

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**Nurses (2)** for 24-bed hospital & nurses' home both up to date & modern. Salary: $175 per mo. with full maintenance. Usual holidays with pay, sick leave, etc. Transportation refunded if nurse stays a yr. or longer. Apply Matron, Union Hospital, Vanguard, Sask.

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**General Staff Nurses** for newly constructed hospital. Starting salary: $175 per mo. plus $10 differential for afternoon duty. Additional pay for post-graduate study & operating room technique & obstetrics. Good personnel policies. Apply Director of Nurses, General Hospital, Guelph, Ont.

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**General Staff Nurses** for 300-bed hospital—medical, surgical & pediatric services. Salaries: $1,620-1,920. Additional $10 per mo. for evening or night duty. Full maintenance provided. Attractive new nurses' residence. For further information apply Director of Nursing, Tuberculosis Hospital, East Saint John, N.B.

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**Graduate Nurses for General Staff Duty** in 350-bed Tuberculosis Hospital. For further information apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

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**Registered Nurses for General Duty.** 35-bed active General Hospital, 50 miles from Toronto. Gross salary: $178 per mo. Apply Supt., Lord Dufferin Hospital, Orangeville, Ont.

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**Registered Nurses for General Duty** for small General Hospital. Salary: $140 per mo. with full maintenance. 6-day wk. 8-hr. duty, rotating shifts, 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. 6 statutory holidays. 28 days holiday. Apply Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

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**Educational Director, Night Supervisor, General Staff Nurses for Maternity & General Wards.** School of Nursing, approx. 200 students. Salary in accordance with position & qualifications as recommended by Sask. Reg. Nurses' Ass'n. For further details regarding positions apply Director of Nursing, City Hospital, Saskatoon, Sask.

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**Asst. Director of Nurses, Clinical Instructor & General Duty Nurses.** Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

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**Obstetrical Supervisor & Staff Nurses** for Archer Memorial Hospital, Lamont, Alta. Salary—prevailing schedule. Cost of Living Bonus. 5% increase bi-yearly. 1 mo. holiday at end of each yr.'s service. 8-hr. day, 1½ days off ea. wk. 1 long week-end ea. mo. Time allowed for all statutory holidays. Apply Supt. of Nurses.

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**Instructor** (qualified) to begin duties in July, 1953. Salary: $240 gross. **Head Nurse for Private Wing** (27 beds). Salary: $215 gross. **General Duty Nurses** for Obstetrical, Medical & Surgical floors. Salary: $180-195 gross depending on experience. 44-hr. wk. 2½ days holiday per mo. Half day on statutory holidays. 1½ days sick time per mo., cumulative to 30 days. Charge of $30 per mo. for board & room. Apply Mrs. M. Alexander, Acting Director of Nursing, General Hospital, Medicine Hat, Alta.

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**Matron (1) & Nurse (1)** for Union Hospital, Lucky Lake, Sask. Salaries: $200 & $175 plus maintenance, respectively. Apply G. D. Clark, Sec.-Treas., Lucky Lake, Sask.

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**Head Nurses** for approved 235-bed hospital. Few hours from Portland & Seattle. 40-hr. wk. Paid vacation. Sick leave & Blue Cross. Salary: $255-295 per mo. $20 bonus for P.M. duty; $10 nights; $10 surgery, delivery room & isolation. Apply Director of Nursing Service, St. Elizabeth Hospital, Yakima, Washington.

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**Dietitian** immediately for 85-bed General Hospital in Central B.C. Salary range: $220-240 per mo. Board & lodging available at nominal charge. Apply Prince George & District Hospital, Prince George, B.C.

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**Registered Nurses** with Public Health training & experience, preferably generalized. Not over 35 yrs. of age. Initial salary: $2,700 with annual increment. Pension scheme available. Apply Director, Nursing Service, Ontario Society for Crippled Children, 92 College St., Toronto 2, Ont.

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# Official Directory

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**Past President**... ..... Miss Ethel Cryderman, V.O.N., 281 Sherbourne St., Toronto 2, Ont.
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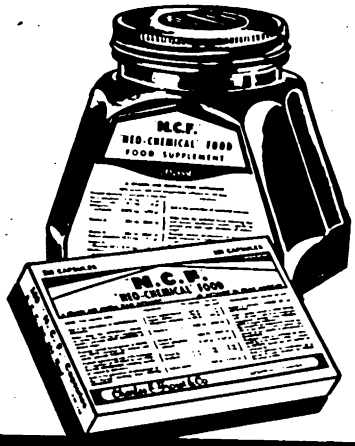
**Makers of Baby Cereals • Strained Foods • Junior Foods**

# FOR YEAR ROUND HEALTH and VITALITY




# "NEO-CHEMICAL" FOOD

**Capsules for Adults**
Available in
25, 50 and 125 day sizes.

**Fluid for Children**
Available in
24, 72 and 144 day sizes.

**DOSAGE:** 2 teaspoonfuls of the fluid, or 2 capsules daily. For infants too young to be fed from a spoon, the fluid may be mixed with milk.

## *A Truly Economical Food Supplement*

Neo-Chemical Food is not a 'medicine' but a preparation that provides essential vitamins and minerals, in a form that is easily and naturally absorbed by the body. Often some of these factors are inadequately supplied in the daily diet and, if the insufficiency continues, subnormal health and vitality result. A food supplement is needed *regularly* to make up for the deficiency.

Neo-Chemical Food supplies adequate amounts of those biochemical factors which all nutritionists emphasize as being of extreme importance, and which tend to be deficient in unsupplemented diets.

Frosst
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Charles E. Frosst & Co. MONTREAL, CANADA